STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017064	A. BUILDING: _____ B. WING _____	R-C 12/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and follow-up survey, and complaint investigation on December 13, 2017 through December 15, 2017 and December 18, 2017 through December 21, 2017.	D 000	Responses to the cited deficiency does not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set-forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law.	
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to maintain floors and walls that were clean and in good repair as evidenced by dirt and dust accumulation on the edges and at the corners of the floors and underneath beds in fourteen resident rooms, two common bathrooms, the Gentlemen's dining room and common hallways in the Special Care Unit (SCU); walls with damaged paint, drip marks and stains in five resident rooms on the SCU and one resident room on the Assisted Living (AL) side, six resident bathrooms on the SCU and near the counter space in the gentlemen's dining room on the SCU; stained and damaged floors in three resident rooms on the SCU and two resident rooms on the AL side; missing toilet paper holders, exposed brackets and damaged doors in four resident rooms on the SCU; and a missing section of countertop molding in one	D 074	Executive Director (ED) met with housekeeping on 12/27/17 to discuss job expectations and implemented new process which includes reporting areas of deep cleaning completed. ED will follow up to ensure accuracy for completion. All rooms will be closely monitored by ED, Care Manager (CM) and Business Office Manager (BOM) through routine monitoring. ED will monitor and report housekeeping needs. Facility will continue to use maintenance log to enter all work orders and follow up weekly with maintenance to ensure requests are completed. Plan of correction date is 2/4/18.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christian Smith — TITLE: Administrator — (X6) DATE: 2/8/18

Reviewed & Accepted for
Darlene Parker /
Bridget Rackley 2/22/18

Division of Health Service Regulation

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christian Smith	Administrator	2/8/18

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D 074	Continued From page 1 resident room on the AL side. The findings are: Review of the facility's Environmental Health Inspection report dated 10/6/17 revealed: -There was a notation of two demerits under the section marked "Floors, Walls and Ceilings." -There was a hand written comment at the bottom of the 1st page of the report, "Floors throughout the facility showing dust especially in corners and hard to reach areas. Also where some A/C (air conditioning) unit cords are, very dusty. Floors must be kept clean." -There was a hand written commentthat read, "Bathrooms in patient rooms showing they need general cleaning especially on handicap rails, around the sides of the toilets and bases." -The facility's total score was 90.5. Observations on the Special Care Unit (SCU) on 12/13/17 from 11:15am until 12:40pm revealed: -There was heavy accumulation of dirt and dust behind the entrance doors, in the corners, and along the edges of the floors in resident rooms 108, 109, 110, 302, 303, 304, 305, 307, 309, 313, 314, 315, 316 and an unmarked resident room, the Gentlemen's dining room and common bathroom and the common shower and bathing room. -In resident room 302, there were yellow/brown drip marks on the wall and baseboard between the bed and air unit, and heavy dust accumulation under the bed. -The bathroom wall in resident room 313, had yellow drip marks and smudges from chest to waist height on the wall around the light switch. -In resident rooms 305 and 314, there were yellow drip marks and black smudges on the walls between the windows and the dressers.	D 074		

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D 074	Continued From page 2 -In the bathroom in resident room 316, there was a large yellow stain (approximately the size of a small bath mat) on the floor in front of the toilet. -In the common bathroom in the Gentlemen's dining room and in the bathrooms in resident rooms 305, 307, 313, 314 and 316, there were yellow/brown drip marks on the walls next to the toilets. -The wall next to the sink and cabinet doors under the counter in the Gentlemen's dining room had yellow/orange drip marks. Observations on the SCU on 12/13/17 from 11:15am until 12:40pm revealed: -The common shower and bathing room and the bathroom in resident room 313 had missing toilet paper holders leaving the mounting brackets protruding from the wall with no toilet paper next to the toilets. -In resident room 106, the 1st folding closet door was off the track. -In resident room 110, there were marks of peeled and missing paint, two screw sized holes and an area of discoloration approximately the size of a basketball on the wall next to the bed. -In the bathroom inside resident room 110, there was one exposed bracket with sharp edges mounted on the wall at approximately chest height next to the shower. -In resident room 302, there was rust and rot approximately three inches in height from the floor on the metal door jamb to the bathroom. -In resident room 305, the floor in front of the wardrobe closet had a section of approximately four inches in width that was warped. -In resident room 307, the floor transition plate to the bathroom was missing and the caulk around the sink was peeling and cracked. -In resident room 313, there were eight marks of peeled and missing paint and two screw sized	D 074		

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D 074	Continued From page 3	D 074		

holes on the wall above the television.
-In resident room 316, the baseboard was ajar from the wall approximately two inches in width and 12 inches in length.

Interview with a Personal Care Aide (PCA) on 12/13/17 at 4:19pm revealed:
-She had become accustomed to the way the floors and walls looked and just did not see any dust accumulation or stains on the walls.
-She had not noticed any needed repairs on the SCU.
-Any housekeeping concerns and needed repairs were reported to the Administrator.

Interview with the SCU Housekeeper on 12/15/17 at 9:30am revealed:
-Before the housekeeper began cleaning the residents' rooms, he would make rounds on the unit, and prioritize cleaning the rooms, based on the cleanliness of the rooms.
-He sprayed the sink, and commode in the residents' bathrooms daily.
-He waited for 10 minutes and wiped the spray off the sink and the commode.
-He mopped the bathroom floor daily, and the bedroom floor twice weekly and as needed.
-He moved the beds and nightstands into the middle of the floor weekly to clean underneath the furniture.
-He wiped down the baseboards, lamps and window sills weekly.
-The blinds in the residents' rooms were dusted weekly.
-The hallway, dining room and dayroom were cleaned daily.

Second interview with the SCU Housekeeper on 12/15/17 at 1:19pm revealed:
-He tried to "get under the beds" with the dust

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D 074	Continued From page 4 mop twice a week. -He did not have a response for the edges and corners of the floors on the SCU. -The Gentlemen's dining room was supposed to be cleaned by 3rd shift staff. -He was responsible for cleaning the bathrooms and all the floors in the SCU. -He did not get to clean the walls around the toilet every day, but he did clean the bathrooms every day. -He cleaned the walls when he could, "maybe once a week." -He wrote down any repair needs and gave it to the Administrator. -He had reported the warped floor and missing toilet paper holders to the Administrator, but he did not know when. -The Maintenance Technician was in the facility last week working on repairs. Interview with the Memory Care Manager (MCM) on 12/13/17 at 4:41pm revealed: -Housekeepers reported directly to the Administrator. -She was not aware of the dirt and dust accumulation and stains on the walls in the Gentlemen's dining room and bathrooms on the men's hall (300 hall). -She could not recall specific repairs that may have been mentioned at the daily stand up meetings where staff discussed any concerns in the facility. -She knew that there were ongoing repairs the Administrator had put in a request for, but was not sure of which repairs had been requested and when. -She was not sure who was responsible for monitoring that housekeeping duties were completed.	D 074		

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D 074	Continued From page 5 Observation of resident room 505 on 12/13/17 at 11:44 a.m. revealed: -The paint had been scratched off the wall behind both Bed A and Bed B. -The damaged area behind Bed A was 36 inches by 1 inch with sheet rock exposed. -The damaged area behind Bed B was 24 inches by 1 inch with sheet rock exposed. Interview with the residents who resided in room 505 on 12/13/17 at 11:45 a.m. revealed: -The wall had been like that since they moved in. -They did not know what happened to the wall. -They did not recall if they had told anyone about the wall. - "They see it when they come in here so I know they know about it." Observation of suite 512 on 12/13/17 at 11:55 a.m. revealed a 20 inch piece of molding was missing from the countertop of the sink and cabinet unit. Observation of resident rooms 505 and 506 revealed the outside of the entry door had multiple areas that the stain had been scratched, revealing the wood on the bottom portion of the door. Interview with the Maintenance Technician on 12/18/17 at 10:07 a.m. revealed: -He did general maintenance at the facility, preventive maintenance and completed work orders for things that needed to be done. -He was usually at the facility 2 days per week. Interview with a second Housekeeper on 12/18/17 at 10:15 a.m. revealed: -He was responsible for cleaning resident rooms and common areas.	D 074		

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D 074	Continued From page 6 -If he saw something that needed to be fixed, he would tell the Administrator. -The Administrator would walk with him and "eye-ball" the things reported. -He had reported the walls being scraped up in room 505, but he did not recall when he reported it. -The residents were rough on the walls and furniture. -He had reported the missing molding in suite 512, but he did not recall when he had reported it. -He was aware the entry doors to resident's rooms 505 and 506 were scratched up. -They were working on "all this now." Interview with the Maintenance Technician on 12/20/17 at 12:10 p.m. revealed: -He was not aware of the walls being damaged in room 505. -He had been patching and painting walls as needed. -The baseboard had been pulled off the wall in the SCU "a while back" due to a pipe that had busted and the base board was never replaced. -The baseboard was off in May 2017 when he started working at the facility. -In a month's time, he went in every room doing water temperatures and if he saw something that needed to be done, he would complete a work order on it. -The Housekeeper told him a lot of things that needed to be done. -When someone showed him something that needed to be done, he would write up a work order, submit it to his director, complete the work and then sign off on it. -He had been working in room 110, patching, sanding and painting. -The transition board/strip and linoleum had been put on a work order last night, 12/19/17.	D 074		

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D 074	Continued From page 7 -Prior to receiving the work-order, he did not know this was a problem. -He was not aware of any problems with 302. -He had received a work order for resident rooms 307, 309, 106, and 110 dated last night (12/19/17). -The work orders he received showed that Room 106 had a closet door off track, the SCU spa needed a toilet paper holder, and room 110 needed painting. -The wall bracket being exposed in room 110 was not on the work-order. -He was not aware of room 316 having any problems. -He was not aware of a damaged wall in room 313. Observation of resident room 615 private bathroom on 12/13/17 at 11:50 a.m. revealed: -The bathroom smelled like urine. -There was a large brown stain on the laminate floor under the sink that led to the side of the toilet. -There was a puddle of water underneath the bathroom sink. -The caulking around the base of the toilet was dark brown. -The bottom of the rubber baseboards on all four walls had built-up black dirt. -The floor of the shower had built-up brown stains throughout the floor. -The caulking between the side of shower floor and the laminate floor had multiple cracked areas. -Four inches of the bottom of the rubber baseboards on one of four walls was concaved. Interview with the resident, who resided in resident room 615, on 12/13/17 at 11:55 a.m. -Housekeeping cleaned his bathroom daily.	D 074		

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D 074	Continued From page 8 -Staff had not cleaned his bathroom on 12/13/17. -He had not noticed a puddle of water under his sink. -His bathroom has had the cracked caulking around the baseboard and the built-up dirt around the baseboards since October 2017. -He did not have a problem with the cleanliness of his bathroom. Interview with a Housekeeper on 12/13/17 at 11:57 a.m. revealed: -He had not cleaned Resident Room #615. -He would go to the resident's room and clean the puddle of water on the bathroom floor. A second observation of resident room 615 on 12/13/17 at 5:12 p.m. revealed: -The bathroom smelled like urine. -The resident urinated on the floor in the bathroom. -The puddle of water under the bathroom sink had been removed. -There was no change with the above concerns in the bathroom. -There was a large brown stain on the laminate floor under the sink that led to the side of the toilet. -The caulking around the base of the toilet was dark brown. -The bottom of the rubber baseboards on all four walls had built-up black dirt. -The floor of the shower had built-up brown stains throughout the floor. -The caulking between the side of shower floor and the laminate floor had multiple cracked areas and the linoleum floor was loosed on the sides. -Four inches of the bottom of the rubber baseboards on one of four walls was concaved. Observation of the bathroom in resident room	D 074		

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D 074	Continued From page 9 suite 611 on 12/13/17 at 12:33 p.m. revealed: -The caulking around the base of the toilet was dark orange and brown. -The caulking between the side of shower floor and the laminate floor had multiple cracked areas. -The floor of the shower had built-up brown stains throughout the floor. A second observation the bathroom in resident room suite 611 on 12/15/17 at 9:43 a.m. revealed the same observations as above. On 12/13/17 at 5:20 p.m., the surveyor informed the Administrator of the concerns of the private bathroom in resident room 615 and the bathroom in resident room suite 611. Interview with a Housekeeper on 12/15/17 at 9:43 a.m. revealed: -The bathrooms at the facility were cleaned daily. -She cleaned resident room 615 daily and sometimes twice daily. -She cleaned resident room 615 bathroom the morning of 12/15/17. -The resident, who lived in room 615, urinated on the floor in the bathroom and sometimes the resident poured the urine in the urinal on the floor in the bathroom and the urine runs under the sink in the bathroom and around the base of the toilet. -She was aware of the caulking coming up and the loosed area on the linoleum floor by the shower in the bathroom in resident room 615. -She was not aware of the the loosed area on the linoleum floor by the shower in the bathroom in resident room suite 611. -She did not know if the Administrator was aware of the caulking coming up and the loosed linoleum by the shower on the floors in the bathrooms in resident room 615 and resident	D 074		

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D 074	Continued From page 10 room suite 611. -If something needed to be repaired, she reported it to the Administrator. Interview with a second Housekeeper on 12/15/17 at 10:05 a.m. revealed: -The cracked caulking in some of the bathrooms at the facility had been like that for over a month. -He reported the cracked caulking to the Administrator and Maintenance. -The floors were cleaned daily in the resident bathrooms. -He was not allowed to use a strong cleaning solution in the bathrooms. -He used a cleaning solution to clean around the baseboards weekly. -He last used the cleaning solution last week (between 12/3/17 to 12/9/17). Interview with the Administrator on 12/15/17 at 11:07 a.m. revealed: -The floors, baseboards and walls were in the process of renovations that had started approximately six months ago. -Cleaning baseboards and dusting were done as needed, meaning when the Housekeepers saw the accumulation the floors and baseboards should be cleaned. -Six months ago, Maintenance recaulked the tile in some of the bathrooms as needed. -He was aware of the cracked caulking on the floors in the bathrooms. -Housekeeping used a cleaning solution to help get rid of the the stains around the toilet. -He was aware of the stains around the caulking of the base of the toilet. -It had been like that for the past 3 months. -Sometimes the cleaning solution helped to clean around the toilet and sometimes it did not help. -He was aware of the baseboards in the	D 074		

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D 074	Continued From page 11 bathrooms. -The baseboards had been like that for the past 6 months. -He was in the process of getting the baseboards repaired or repainted at the facility. -Staff reported any maintenance and/or housekeeping concerns directly to the Administrator. -He was always walking through each hall of the building making observations. -He was periodically in resident rooms each day. -He checked the cleanliness of the building each day. -He was responsible for supervising the housekeeping staff. -He was not aware of the comments documented on the Environmental Health Inspection report dated 10/6/17 regarding the floors, walls and bathrooms. -There was a maintenance technician in the facility twice a week. -When repairs were needed, he submitted a request to the facility's Maintenance Director or if the maintenance technician was in the facility, he went directly to him. -The Maintenance Technician would walk the Administrator through the building upon completion of repairs and the Administrator also received an email confirmation for completed repairs. -He had submitted some of the maintenance concerns (exposed brackets, peeling sink caulk, missing floor transition plates, loose baseboards and warped flooring) to the Maintenance Director in the last three months, but could not recall what specific requests had been submitted. -He was unable to provide documentation of maintenance requests because it was an internal process. -He was aware of the toilet paper holders and	D 074		

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D 074	Continued From page 12 need for painting of the walls and had submitted a request for repairs.	D 074		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term,	D 188	ED, CM, and/or BOM will review staffing daily for all shifts to ensure shifts are staffed according to regulation. ED will continue to hire and train qualified staff for all three shifts. ED and CM will monitor staffing needs and call outs. Any identified scheduling concerns will be addressed by ED. The ED, CM, Supervisor-In-Charge (SIC) will call staff not on schedule to ensure adequate staffing. Plan of correction date is 2/4/18.	

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D 188	Continued From page 13 "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure aide hours met the minimum requirements on 18 of 45 shifts sampled from 5/19/17-5/20/17; 5/31/17-6/1/17; 7/1/17-7/2/17; 10/22/17;10/28/17-10/29/17; and 11/10/17-11/11/17, resulting in inadequate staff available to provide personal care and supervision for a census of 42 - 49 residents on the Assisted Living (AL). The findings are: Telephone interview with a family member on 12/13/17 at 7:00pm revealed: -She visited a resident daily at the facility. -There was not enough staff in the facility. -There were times when there was one Personal Care Aide (PCA) on the AL side and one staff could not take care of the residents alone. -The Administrator would make staff from the last shift stay if the oncoming shift staff did not show up. -Staff that had to stay were mad and would take it out on the residents. Interview with a second guardian/family of a resident on 12/18/17 at 1:30 p.m. revealed: -There were hardly any staff on the floor during	D 188		

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D 188	Continued From page 14 second shift and on the weekends. -There was not enough staff working on the floor. -The few staff that were working at the facility were too busy in the bathrooms or in the dining rooms assisting residents and were not available on the halls. -The family member had to walk around to locate a staff person. Confidential interview with a resident, who lived on the AL, revealed: -There were usually 3 to 4 PCAs and 2 MAs working at the facility. -There were not enough staff working at the facility. Confidential interview with a second resident, who lived on the AL, revealed: -There was usually 2 PCAs and 2 MAs working at the facility. -When it snowed this past weekend (12/9/17 to 12/10/17), there was one PCA working on the AL. Confidential interview with a staff revealed: -The staff worked all three shifts. -Since June 2017, the usually staffing pattern during first and second shifts were 2 PCAs, and 2 MAs on the AL. -During third shift, 2 PCAs worked on the AL, and there was 1 MA who worked on the AL and SCU. Confidential interview with a second staff revealed: -The staff worked first and second shift. -There were usually 2 PCAs and 2 MAs during first and second shifts. -The staff did not know about the staffing pattern during third shift. Confidential interview with a third staff revealed:	D 188		

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D 188	Continued From page 15 -There were not enough staff to work the floor and assist the residents. -When behaviors occured, staff were few in number and were tied up in the bathrooms or helping another resident in their room and could not intervene. -Staff had to work over several times during the month to cover both the AL and SCU units. Confidential Interview with a fourth staff revealed: -Staff were usually spread thin and there were not enough to do the job. -The facility also employed a red dot system which placed a mark beside the name of a staff each designated to stay if the oncoming shift was short staffed. -Usually this led to staff not doing the job they were supposed to do because they did not want to be there and were tired. Review of staff punch details, staff schedule and daily census report for 5/19/17 revealed: -There were 49 residents in the AL which required 16 aide hours for 3rd shift. -There were 11.27 aide hours for 3rd shift leaving the AL short 4.73 aide hours. -There were 87 residents in the facility (38 in the Special Care Unit), which required 46.4 aide hours for 3rd shift. -There were 32.85 aide hours for the building for 3rd shift, leaving the building short by 13.55 aide hours. Review of staff punch details, staff schedule and daily census report for 5/20/17 revealed: -There were 49 residents on the AL side which required 20 aide hours for 1st and 2nd shift, and 16 aide hours for 3rd shift. -There were 18.7 aide hours for 1st shift leaving the AL side short 1.3 aide hours.	D 188		

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D 188	Continued From page 16 -There were 17.13 aide hours for 2nd shift leaving the AL side short 2.87 aide hours. -There were 11.07 aide hours for 3rd shift leaving the AL side short 4.93 aide hours. -There were 88 residents in the facility (39 in the Special Care Unit), which required 59 aide hours for 1st and 2nd shift and 47.2 aide hours for 3rd shift. -There were 48.18 aide hours for the building for 1st shift, leaving the building short by 10.82 aide hours. -There were 49.3 aide hours for the building for 2nd shift, leaving the building short by 9.7 aide hours. -There were 32.94 aide hours for the building for 3rd shift, leaving the building short by 14.26 aide hours. Review of staff punch details, staff schedule and daily census report for 5/31/17 revealed: -There were 48 residents on the AL which required 20 aide hours for 1st shift. -There were 11.2 aide hours for 1st shift leaving the AL side short 9.55 aide hours. -There were 85 residents in the facility (37 in the Special Care Unit), which required 57 aide hours for 1st shift. -There were 46.93 aide hours for the building for 1st shift, leaving the building short by 10.07 aide hours. Review of staff punch details, staff schedule and daily census report for 06/01/17 revealed: -There were 46 residents in the AL which required 20 aide hours for 1st and 2nd shift and 16 hours for 3rd shift. -On 06/01/17, there were 28.02 aide hours for 1st shift, 15.8 aide hours for 2nd shift and 8.16 hours for 3rd shift leaving the facility short-staffed by 4.20 aide hours on 2nd shift and 7.84 hours for	D 188		

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D 188	Continued From page 17 3rd shift. -There were 46 residents on the AL side and 39 residents in the SCU. Required hours for the building for 1st and 2nd shift based on a census of 46 AL and 39 residents in the SCU was 59 aide hours. Required hours for the building for 3rd shift based on a census of 46 AL and 39 residents in the SCU was 47.2 aide hours. -There were 63.07 aide hours documented for the building for 1st shift. -There were 51.17 aide hours documented for the building for 2nd shift leaving the building short 7.83 hours. -There were 29.65 aide hours documented for the building for 3rd shift leaving the building short 17.55 hours. Review of staff punch details, staff schedule and daily census report for 07/01/17 revealed: -There were 42 residents in the AL which required 20 aide hours for 1st and 2nd shift and 16 hours for 3rd shift. -On 07/01/17, there were 30 aide hours for 1st shift, 28.06 aide hours for 2nd shift and 21.84 hours for 3rd shift. -There were 42 residents on the AL side and 41 residents in the SCU. Required hours for the building for 1st and 2nd shift based on a census of 42 AL and 41 residents in the SCU was 61 aide hours. Required hours for the building for 3rd shift based on a census of 42 AL and 41 residents in the SCU was 48.8 aide hours. -There were 58 aide hours documented for the building for 1st shift leaving the facility short 3 aide hours. -There were 56.95 aide hours documented for the building for 2nd shift leaving the building short 4.05 aide hours. -There were 36.02 aide hours documented for the building for 3rd shift leaving the building short	D 188		

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D 188	Continued From page 18 12.78 aide hours. Review of staff punch details, staff schedule and daily census report for 07/02/17 revealed: -There were 46 residents in the AL which required 20 aide hours for 1st and 2nd shift and 16 aide hours for 3rd shift. -On 07/02/17, there were 24.73 aide hours for 1st shift, 28.16 aide hours for 2nd shift and 25.98 aide hours for 3rd shift -There were 46 residents on the AL side and 38 residents in the SCU. Required hours for the building for 1st and 2nd shift based on a census of 46 AL and 38 residents in the SCU was 58 aide hours. Required hours for the building for 3rd shift based on a census of 46 AL and 38 residents in the SCU was 46.4 aide hours. -There were 54.17 aide hours documented for the building for 1st shift leaving the building short 3.83 hours. -There were 52.58 aide hours documented for the building for 2nd shift leaving the building short 5.42 hours. -There were 47.84 aide hours documented for the building for 3rd shift. Review of staff punch details, staff schedule and daily census report for 10/21/17 revealed: -There were 45 residents in the AL which required 20 aide hours for 1st and 2nd shift and 16 hours for 3rd shift. -On 10/21/17, there were 16.06 aide hours for 1st shift, 29.16 aide hours for 2nd shift and 11.29 for 3rd shift leaving the facility short-staffed by 3.91 aide hours on 1st shift and 8.71 hours for 3rd shift. -There were 45 residents on the AL side and 38 residents in the SCU. Required hours for the building for 1st and 2nd shift based on a census of 45 AL and 38 residents in the SCU was 58 aide hours. Required hours for the building for 3rd shift	D 188		

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D 188	Continued From page 19 based on a census of 45 AL and 38 residents in the SCU was 46.4 aide hours. -There were 59.29 aide hours documented for the building for 1st shift. -There were 52.31 aide hours documented for the building for 2nd shift leaving the building short 5.69 hours. -There were 18.77 aide hours documented for the building for 3rd shift leaving the building short 27.63 hours. Review of staff punch details, staff schedule and daily census report for 10/22/17 revealed: -There was 44 residents in the AL which required 20 aide hours for 1st and 2nd shift, and 16 aide hours for 3rd shift. -On 10/22/17, there were 16.68 aide hours for 1st shift, 22.9 aide hours for 2nd shift and 11.68 aide hours for 3rd shift leaving the facility short-staffed by 3.32 aide hours on 1st shift and 4.32 aide hours on 3rd shift. -There were 44 residents on the AL and 38 residents in the SCU. Required hours for the building for 1st and 2nd shift based on a census of 44 in AL and 38 residents in the SCU was 58.00 aide hours. Required hours for the building for 3rd shift based on a census of 44 in AL and 38 residents in the SCU was 46.4 aide hours. -There were 54.68 aide hours documented for the building for 1st shift on 10/22 leaving the building short by 3.32. -There were 63.3 aide hours documented for the building for 2nd shift. -There were 30.43 aide hours documented for the building for 3rd shift on 10/22/17 leaving the building short by 15.97 aide hours. Review of staff punch details, staff schedule and daily census report for 10/28/17 revealed: -There were 43 residents in the AL which required	D 188		

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D 188	Continued From page 20 20 aide hours for 1st and 2nd shift, and 16 aide hours for 3rd shift. -On 10/28/17, there were 15.00 aide hours for 1st shift, 20.00 aide hours for 2nd shift and 7.25 aide hours for 3rd shift leaving the facility short-staffed by 5.00 aide hours on 1st shift and 8.75 aide hours on 3rd shift. -There were 43 residents on the AL and 37 residents in the SCU. Required hours for the building for 1st and 2nd shift based on a census of 43 in AL and 37 residents in the SCU was 57 aide hours. Required hours for the building for 3rd shift based on a census of 43 in AL and 37 residents in the SCU was 45.6 aide hours. -There were 50 aide hours documented for the building for 1st shift on 10/28/17 leaving the building short by 7.00 aide hours. -There were 54.25 aide hours documented for the building for 2nd shift on 10/28/17 leaving the building short by 2.75 aide hours. -There were 40.00 aide hours documented for the building for 3rd shift on 10/28/17 leaving the building short by 5.6 aide hours. Review of the staff punch details, staff schedule, and daily census report dated 10/29/17 revealed: -There were 45 residents on the AL side which required 20 aide hours for 1st and 2nd shift, and 16 aide hours for 3rd shift. -There were 12.15 aide hours documented for 3rd shift on the AL side of the facility which left the facility short a total of 3.85 aide hours. Review of the staff punch details, staff schedule, and daily census report dated 11/10/17 revealed: -There were 44 residents on the AL side which required 20 aide hours for 1st and 2nd shift, and 16 aide hours for 3rd shift. -There were 21.73 aide hours documented for 2nd shift on the AL side of the facility which left	D 188		

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D 188	Continued From page 21 the facility short a total of 2.27 aide hours. -There were 14 aide hours documented for 3rd shift on the AL side of the facility which left the facility short a total of 2 aide hours. Review of the staff punch details, staff schedule, and daily census report dated 11/11/17 revealed: -There were 44 residents on the AL side which required 20 aide hours for 1st and 2nd shift, and 16 aide hours for 3rd shift. -There were 13.66 aide hours documented for 3rd shift on the AL unit which left the facility short a total of 2.34 aide hours. Review of staff punch details, staff schedule and daily census report for 12/10/17 revealed: -There were 48 residents in the AL which required 16 hours for 3rd shift. -On 12/10/17, 14.94 hours for 3rd shift on the AL leaving the facility short of 1.06 aide hours. -There were 48 residents in the AL side and 39 residents in the SCU. Required hours for the building for 3rd shift based on a census of 48 AL and 39 residents in the SCU was 47.2 aide hours. -There were 26.90 hours for the building for 3rd shift leaving the building short 20.30 hours. Interview with the Memory Care Manager (MCM) on 12/19/17 at 11:00 am revealed: -She had been covering as the MCM and as the Resident Care Manager (RCM) since she started working at the facility in June 2017. -She was responsible for overseeing bot the SCU and the AL. -She was responsible for assisting staff with any needs or concerns they had in providing care for the residents. -She tried to spend the majority of her day on the SCU, but the printer for all documents was on the AL side and all meetings were on the AL side.	D 188		

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D 188	Continued From page 22 -She estimated that two to three hours of her day were spent on the AL side. Interview with the MCM on 12/20/17 at 2:49 pm and 12/21/17 at 2:13 pm revealed: -There staffing issues related to call outs and high turnover in staff at the facility. -She had stayed and worked 2nd shift and she had come in to cover 3rd shift because there was no else to work. -She had not kept track of hours and shifts she had worked covering as direct care staff. -Sometimes she may have come in at 4:00am or 5:00am because of an emergency or a call out. -She could not remember the last time she had to stay for 2nd shift or come in for 3rd shift. -She worked once for a full 2nd shift and came in twice on 3rd shift since she started working at the facility in June 2017. Interview with the MCM on 12/21/17 at 2:13 pm revealed: -When there was one MA on duty for 3rd shift, the MA's time was split between the AL side and the SCU. -For example, if the MA worked 8 hours on 3rd shift, four hours were on the AL side and four hours were on the SCU. Interview with the Administrator on 12/21/17 at 2:13pm revealed: -He was aware the facility had staffing issues. -The facility had a red dot system in place to cover short shifts. -The red dot system identified a staff each shift who was designated to stay and work if the oncoming shift was short staffed. -All staff who worked a given shift were accounted for on the punch details report.	D 188		

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D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide the supervision necessary to prevent 3 of 11 sampled residents (#1, #2, #9), with known physical aggression and sexually expressive behaviors, from hitting, pushing and pursuing other residents on the Special Care Unit (SCU) resulting in one resident sustaining a broken pelvis (#10) and another resident (#1), who was incapable of consenting due to cognitive status, being lured into an unwitnessed sexual encounter. The findings are: 1. Confidential interview with a staff revealed: -Resident #9 was recently Involuntarily Committed (IVCd) after assaulting several residents. -Resident #9 had a pattern of hitting residents. -Resident #9 had pushed Resident #10 down to the floor in the day room and caused Resident #10 to have a broken hip about a month ago (November 2017). -There were no interventions put in place after Resident #9 hit other residents except to change	D 270	Staff was in-serviced on systems process including fall management program, rounding and hot box process as well as redirecting when behaviors occur. On 12/14/17, Mood/ Behavior monitoring and communications form was implemented to identify and monitor interventions. When a behavior occurs, staff will identify root cause to determine most effective intervention. Resident interventions vary and each resident shall be considered case by case. The Primary Care Physician (PCP) is notified of behaviors and referral for psychiatric services is given for a licensed provider to determine best interventions. Community supervisors will implement interventions based on need and recommendations. Residents are identified with falls by following the fall management program. System process will be reviewed upon hire for new staff during orientation by the Executive Director or Designee. The ED andCM will monitor systems through	

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D 270	Continued From page 24 Resident #9's medications. -Staff were not given instructions to increase the monitoring of Resident #9. -There was nothing staff could do. -Resident #9 was sent to the hospital after hitting two residents and had some medication changes before the incident with Resident #10 (November 2017). -A week after returning from the hospital, Resident #9 slapped another resident. -Staff would try to "stay on her" unless Resident #9 was in her room. -Many staff were afraid of her because the staff knew Resident #9's history of hitting staff. -Most days there were three Personal Care Aides (PCAs) and one Medication Aide (MA) on 2nd shift in the Special Care Unit (SCU) which was not enough for 35-40 residents and specifically for the supervision needs of Resident #9. -The 1st shift usually had enough staff and the 3rd shift was frequently short staffed. -The facility employed a red dot system which placed a mark beside the name of a staff each designated to stay if the oncoming shift was short staffed. -Usually this led to staff not doing the job they were supposed to do because they did not want to be there and were tired. Review of Resident #9's current FL-2 dated 3/29/17 revealed diagnoses included Alzheimer's Dementia, Essential Hypertension, Bilateral Cataracts, Gastro-esophageal Reflux Disease and Arthritis. Review of Resident #9's current care plan dated 3/10/17 revealed: -Resident #9 had wandering, verbally abusive and physically abusive behaviors and was resistant to care.	D 270	random audits, observations, and interviews. An in-service was completed on 12/22/17 by Registered Nurse (RN) which included Managing Aggressive Behavior, Hot Box, Mood/Behavior Log, Communication Log, and The Bucket System. Upon admission, all residents will be put on 72 hour hot box (monitoring) for observation and to establish baseline. When a behavior is identified it will be documented in the Mood/ Behavior and communication binders, supervision will be increased, and care staff will notify management and PCP. Any behavior which escalates to a threat to a resident or others, shall require immediate intervention (move resident out of harms way and call 911) to assure safety. A fall risk assessment will be completed for all new residents. A monthly fall management meeting will be completed to identify at risk residents. Resident diagnosis, history and physical wil be reviewed prior to admission and (preventative) interventions will include redirecting, providing snacks	

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D 270	Continued From page 25 -Resident #9 was receiving services and medications for behaviors/mental illness. Review of electronic Charting Notes and Accident/Injury reports dated 6/1/17 through 12/18/17 revealed there were a total of 15 incidents where Resident #9 had hit, pushed or had an "altercation" with another resident and there was no documentation of interventions such as increased monitoring for Resident #9. Review of an electronic Charting Note dated 6/6/17 at 3:15pm for Resident #9 revealed staff documented Resident #9 hit a resident in the face. Review of an Accident/Injury Report dated 6/6/17 at 2:33pm for Resident #9 revealed staff documented Resident #9 was involved in an altercation with another resident with no injurie. Interview with the Administrator on 12/21/17 at 2:05pm revealed Resident #6 was the resident hit by Resident #9 on 6/6/17. Attempted interview on 12/18/17 at 12:39pm with staff who discovered the incident on 6/6/17 for Resident #9 was unsuccessful. Review of a Mental Health Provider (MHP) visit note for Resident #9 dated 6/13/17 revealed: -Staff reported agitation and Resident #9 had been "fussing." -Resident #9 had not had any recent assaultive behaviors. Review of a Primary Care Provider (PCP) visit note dated 6/29/17 for Resident #9 revealed: -Resident #9 was drowsy and confused on exam. -The dosage of Risperidone was decreased from	D 270	and (administering) as needed medications. An in-service was completed 12/22/17 by RN which included managing aggressive behavior, Hot Box, Mood/Behavior Log, The Bucket System, and Communication log In-service completed by Ombudsmen 1/10/18 and 1/25/18 which included Dementia residents and sexual behaviors and Resident Rights. ED and/or CM will monitor weekly for the first 3 months and routinely thereafter for accuracy and completion. Plan of correction date is 1/20/18.	

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D 270	Continued From page 26	D 270		

twice daily to daily at bedtime. (Risperidone is used to treat symptoms of irritability, bipolar disorder and schizophrenia.)

Review of an electronic Charting Note dated 7/11/17 at 10:30pm for Resident #9 revealed staff documented Resident #9 hit a resident that walked into her room.

Review of an Accident/Injury Report dated 7/11/17 at 1:55pm for Resident #9 revealed staff documented Resident #9 was "standing in room by door" and the PCP was notified.

Interview with the Administrator on 12/21/17 at 2:05pm revealed Resident #17 was the resident hit by Resident #9 on 7/11/17.

Attempted interview on 12/18/17 at 12:40pm with staff who completed the Accident/Incident Report dated 7/11/17 for Resident #9 was unsuccessful.

Review of a PCP visit note dated 7/13/17 for Resident #9 revealed:
-Resident #9 struck another resident in the face after the resident entered Resident #9's room, resulting in superficial injuries to the other resident.
-Staff were expected to increase their awareness of Resident #9 to avoid future altercations.

Review of an electronic Charting Note dated 8/2/17 at 11:11pm for Resident #9 revealed staff documented Resident #9 got into an altercation during the 2nd shift mealtime that resulted in a fall.

Review of an Accident/Injury Report dated 8/2/17 at 5:40pm for Resident #9 revealed staff documented Resident #9 was knocked to the

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D 270	Continued From page 27 floor by another resident with no injury and the PCP's office was notifed. Interview with a MA on 12/20/17 at 5:49pm revealed: -He had documented the electronic charting note dated 8/2/17 at 11:11pm for Resident #9. -Resident #9 was knocked down by Resident #6 when Resident #6 had entered Resident #9's room. Review of a PCP visit note dated 8/10/17 for Resident #9 revealed: -Resident #9 was involved in a second altercation with another resident in one month under the exact same circumstances. -Divalproex was added to curtail dementia oriented combativeness. (Divalproex is used to treat symptoms of bipolar disorder.) Review of an electronic Charting Note dated 8/15/17 at 6:40pm for Resident #9 revealed staff documented Resident #9 was observed hitting another resident and staff would continue to monitor. Review of an Accident/Injury Report dated 8/15/17 at 3:40pm for Resident #9 revealed staff documented Resident #9 was observed hitting another resident. Interview with the Administrator on 12/21/17 at 2:05pm revealed Resident #17 was the resident hit by Resident #9 on 8/15/17. Review of a PCP visit note dated 8/17/17 for Resident #9 revealed: -Resident #9 was involved in an altercation with another resident from what appeared to be an intrusion into Resident #9's personal space.	D 270		

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D 270	Continued From page 28 -This was the 3rd occurrence in five weeks under the exact same circumstances. -Divalproex was increased and staff were expected to "play an active role in observing residents ...if territorial, don't let wanderers wander into their territory." Review of a MHP visit note for Resident #9 dated 8/22/17 revealed: -Staff reported Resident #9 became agitated when others came in her room. -Resident #9 was seen by the PCP on 8/17/17 for follow up on an altercation with another resident where Resident #9 was the "instigator." -There were no medication changes. Review of an electronic Charting Note dated 9/15/17 at 8:02pm for Resident #9 revealed staff documented Resident #9 was involved in an altercation with another resident. Review of an Accident/Injury Report dated 9/15/17 at 1:15pm for Resident #9 revealed staff did not document any details or description of an incident, but documented there were no injuries. Interview with the Administrator on 12/21/17 at 2:05pm revealed Resident #6 was involved in the altercation with Resident #9 on 9/15/17. Review of a PCP visit note dated 9/21/17 for Resident #9 revealed: -Staff reported Resident #9 remained territorial and agitated when other residents wandered into her space. -As long as staff could keep other residents out of Resident #9's room, she was fine. -Resident #9 reported on exam she was going to get a big stick and hit them; she did not like when other residents came into her room.	D 270		

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D 270	Continued From page 29 -Staff had been "educated multiple times" to redirect wanderers from Resident #9's room; and there had been no recent altercations in over a month so it seemed to be working. Review of an electronic Charting Note dated 10/18/17 at 4:47am for Resident #9 revealed: -Staff documented Resident #9 hit another resident and employee around 2:00am because she (Resident #9) was mad because the resident was in her (#9) room. -The PCP was notified and ordered for Aprazolam for one time use. (Aprazolam is used to treat anxiety.) Review of an Accident/Injury Report dated 10/18/17 at 2:00am for Resident #9 revealed staff documented Resident #9 was hitting another resident and hit an employee in the forehead; there were no injuries. Interview with the Administrator on 12/21/17 at 2:05pm revealed Resident #9 hit Resident #14 on 10/18/17. Telephone interview with a PCA on 12/20/17 at 4:35am revealed: -Resident #9 "was always having altercations with other residents ...she was real possessive over her stuff and her space, and she could not stand to have a roommate." -Resident #9 was very sweet when she was first admitted to the facility (12/16/15) and did not "start acting like this" until she got a roommate. -She was not sure, but thought Resident #9's 1st roommate was around the beginning of 2017. -Staff had to handle Resident #9 a "certain way" by talking to her "real nice" and giving her snacks. -Each shift tried to keep a staff with Resident #9 at all times except when she was in her room.	D 270		

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D 270	Continued From page 30 -If Resident #9 was in her room, she was fine. Review of a PCP visit note dated 10/19/17 for Resident #9 revealed: -Resident #9 attacked another resident after that resident was transferred into Resident #9's room. -Staff were expected to redirect the resident and avoid placing residents in Resident #9's room. Review of an electronic Charting Note dated 10/30/17 at 12:12pm for Resident #9 revealed: -Staff documented Resident #9 "was involved in an altercation with another resident, hitting her (the other resident) in the face with a shoe three times." -The PCP made medication changes for Resident #9. Review of an Accident/Injury Report dated 10/30/17 at 11:34am for Resident #9 revealed staff documented Resident #9 hit another resident in the face three times, there were no injuries, the PCP was notified and Resident #9 was to have a follow up appointment with the PCP on 11/2/17. Interview with the Administrator on 12/21/17 at 2:05pm revealed Resident #9 hit Resident #14 on 10/30/17. Interview with a second PCA on 12/19/17 at 2:35pm revealed: -She was working on 10/30/17 when Resident #9 hit another resident in the face. -She did not witness the incident. -She could not remember the other resident's name, but the other resident was Resident #9's roommate. Review of a PCP visit note dated 11/2/17 for	D 270		

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D 270	Continued From page 31 Resident #9 revealed: -Resident #9 had been involved in another altercation due to intrusion from the other resident into her space. -Staff were expected to keep other residents out of Resident #9's room to avoid altercations. -Sertraline was increased to improve mood and behavior. (Sertraline is used to treat depression.) Review of an Accident/Injury Report dated 11/4/17 at 6:05pm for Resident #9 revealed staff documented Resident #9 hit another resident in the face; there were no injuries. Review of electronic Charting Notes for Resident #9 revealed there was no entry for the 11/4/17 incident. Interview with the Administrator on 12/21/17 at 2:05pm revealed Resident #9 hit Resident #15 on 11/4/17. Review of an electronic Charting Note dated 11/10/17 at 7:01pm revealed staff documented Resident #9 was standing over another resident that was laying in her room on the floor. Review of an Accident/Injury Report dated 11/10/17 at 5:45am for Resident #9 revealed staff documented Resident #9 was standing over top of another resident that was in her room, there were no injuries and the on call provider at the PCP's office was notified. Interview with the Administrator on 12/21/17 at 2:05pm revealed Resident #1 was the resident on the floor in Resident #9's room on 11/10/17. Review of an Accident/Injury Report dated 11/11/17 at 6:30am for Resident #9 revealed staff	D 270		

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D 270	Continued From page 32 documented Resident #9 was observed hitting another resident, the on call provider at the PCP's office was notified and Resident #9 was sent to the emergency room (ER). Review of an Accident/Injury Report dated 11/11/17 at 6:30am for Resident #15 revealed staff documented Resident #15 "was involved in an altercation with another resident," there were no injuries, the on call provider at the PCP's office was notified, Resident #15 was sent to the ER and returned to the facility with no new orders. Review of an Accident/Injury Report dated 11/11/17 at 7:00am for Resident #9 revealed staff documented Resident #9 was observed hitting another resident, the on call provider at the PCP's office was notified and Resident #9 was sent to the ER. Review of an Accident/Injury Report dated 11/11/17 at 6:55am for Resident #16 revealed staff documented Resident #16 "was observed being hit by another resident in the face," there were no injuries, the on call provider at the PCP's office was notified, Resident #16 was sent to the ER and returned to the facility with no new orders. Review of an electronic Charting Note dated 11/11/17 at 9:17am revealed staff documented Resident #9 hit two residents in the face, the on call provider was notified and instructed staff to send Resident #9 to the ER for evaluation. Review of an electronic Charting Note dated 11/11/17 at 5:53pm revealed staff documented Resident #9 was admitted to the hospital for low calcium and a possible Urinary Tract Infection (UTI).	D 270		

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D 270	Continued From page 33 Review of a hospital discharge summary dated 11/17/17 for Resident #9 revealed: -Resident #9 presented to the emergency department for aggressive behavior and was admitted on 11/11/17 for acute kidney injury. -Resident #9 was on involuntary commitment and had a psychiatric evaluation and medication changes. -Resident #9 required a one to one sitter for safety and redirection throughout the hospitalization. -Resident #9 was calm and cooperative on the day of discharge back to the SCU (11/17/17). Telephone interview with a PCA on 12/20/17 at 4:35am revealed: -She was working the morning of 11/11/17 when Resident #9 hit two residents in the face. -She did not see the incident. -Another PCA reported that Resident #9 had hit a resident who was just walking by. Review of an Accident/Injury Report dated 11/27/17 at 2:47pm for Resident #9 revealed staff documented Resident #9 pushed another resident; there were no injuries. Review of electronic Charting Notes for Resident #9 revealed there was no entry for the 11/27/17 incident. Interview with the Administrator on 12/21/17 at 2:05pm revealed Resident #10 was the resident who was pushed by Resident #9 on 11/27/17. Review of electronic Charting Note dated 10/3/17 through 11/28/17 for Resident #10 revealed: -On 11/27/17 at 11:03pm, staff documented a mobile x-ray was done on Resident #10's right hip which showed a possible fracture.	D 270		

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D 270	Continued From page 34 -Resident #10 was taken to the ER by EMS, the on call provider and responsible party were notified and staff would continue to monitor. -On 11/28/17 at 8:17am, staff documented Resident #10 returned to the facility at 2:30am with a contusion of the right hip and staff would continue to monitor. -On 11/28/17 at 3:30pm, staff documented a late entry for 11/27/17, Resident #10 was "observed sitting on the floor on her bottom." -The PCP was notifed and ordered a mobile x-ray because Resident #10 was complaining of pain. -On 11/28/17 at 3:35pm, staff documented Resident #10 had difficulty walking and complained of pain and was sent to the ER by the PCP for a second opinion. -On 11/28/17 at 10:28pm, staff documented Resident #10 was admitted to the hospital. Interview with a MA on 12/20/17 at 5:49pm revealed: -He was aware of Resident #10 having been pushed to the floor by Resident #9, but was not there when it happened. -Resident #10 and Resident #9 did not get along. -Redirection worked well for Resident #10. -Staff knew that Resident #9 was aggressive and that Resident #10 would fight back. -He instructed staff when he was working to keep Resident #10 away from Resident #9. -He tried to prevent incidents by keeping residents known to be aggressive away from situations that might escalate, and redirecting residents. Telephone interview with a second MA on 12/20/17 at 4:09am revealed: -Resident #9 was usually awake all night and staff would "just try to keep an eye on her." -Most of the problems with Resident #9 came	D 270		

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D 270	Continued From page 35 from her having a roommate. -Resident #10, Resident #14 and a third resident had been Resident #9's roommates and had been hit by Resident #9. -Staff would redirect Resident #9 and distract her with snacks. -When a resident was aggressive and/or combative, staff would complete an incident report for all involved residents and notify the PCP. -The completed incident reports were given to the Administrator to review. -The MAs were responsible for documenting altercations in the residents' charting notes and reporting to the next shift MA, so the resident could be put on the list to see the PCP. Review of a PCP visit note dated 12/1/17 for Resident #9 revealed: -Resident #9 had instigated another altercation which resulted in the other resident sustaining a pelvic fracture. -Prior attempts to IVC Resident #9 had failed. -Resident #9 had instigated eight unprovoked altercations in the past seven months and was a danger to herself, the staff and all residents. -Staff were expected to immediately IVC Resident #9 if she instigated one more fight. Review of an electronic Charting Note dated 12/4/17 at 10:43pm revealed staff documented Resident #9 was IVCd "because of an altercation with another resident." Interview with a second PCA on 12/19/17 at 2:35pm revealed: -Resident #18 was moved to Resident #9's old room on 12/4/17, and Resident #9 saw Resident #18 come out of the room with a sweater. -Resident #9 tried to take the sweater from the	D 270		

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D 270	Continued From page 36 Resident #18. -She tried to break up the confrontation between Resident #9 and the Resident #18, but Resident #9 reached from behind the PCA and slapped Resident #18. -She had to accompany Resident #9 to the hospital, where during the transport, Resident #9 hit the PCA in the nose and spit on the Sheriff Deputy. -Resident #9 had been IVCd once before the 12/4/17 IVC, and it had not done any good. -She reported the incident to the MA on duty and had seen the MA fill out an incident report. -She had not been given any instruction on monitoring Resident #9 or interventions to prevent harm to other residents. -She was only told to "be careful" around Resident #9. -She reported aggressive behaviors to the MA/Manager on duty, the MA/Manager reported to the PCP, the PCP changed the resident's medications and "that was it." Interview with a MA on 12/20/17 at 5:49pm revealed: -On 12/4/17, Resident #9 took Resident #18's jacket; Resident #18 went to take the jacket back and Resident #9 slapped the other resident. -He had notified the MCM, completed an incident report for the 12/4/17 incident for both residents, put the incident report under the Administrator's door and reported the incident to the next shift MA. -When an incident happened, staff were expected to notify the MCM, and the MCM would notify the PCP. Review of Charting Notes and Accident/Incident Reports for Resident #9 revealed there was no documentation of incidents involving Resident #9	D 270		

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D 270	Continued From page 37 and Resident #18 on 12/4/17. Based on observations, interviews and record reviews, Resident #9 was not available for interview due to hospitalization since 12/4/17. Telephone interview with Resident #9's Guardian on 12/20/17 at 5:23pm revealed: -She visited Resident #9 at the facility one to three times a week and usually every weekend. -Resident #9 went to the hospital on 12/4/17 and was moved to behavioral health to get her medications regulated. -Resident #9 did not hear so well and misunderstood what people were saying to her. -It was hard for Resident #9 to not be in her own home. -When Resident #9 was at home, she would spend her time moving clothes from one room to another. -Resident #9 seemed to have gotten worse with her behaviors over the last three or four months because staff had been calling the Guardian more often. -When Resident #9 first got to the facility, she was in a room by herself. -Resident #9 got into an altercation with another resident the first day they moved her with another resident. -Resident #9 got more confused because she was moved from one room to another. Interview with a third MA on 12/19/17 at 11:33am revealed: -Resident #9 would fight anyone, for any reason and had been that way since her admission to the facility (12/16/15). -Staff would "never see it coming," because Resident #9 would "just hall off and hit somebody walking by."	D 270		

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D 270	Continued From page 38 -Resident #9 was "particularly violent" when another resident went into her room. -Resident #9 wandered into other residents' rooms and took their clothes. -Staff would have a difficult time getting other residents' clothes back from Resident #9. -Staff tried to keep Resident #9 calm by seeing what she liked to do and involve her in activities or give her snacks. -The activities and snacks "did not do any good" for Resident #9. -Resident #9 was IVCd on 12/4/17 because staff could not get the resident to stop fighting. -She did not know any specific details of the altercation on 12/4/17. -The younger staff were afraid of Resident #9. -There were enough staff, but the staff did not know how to work with residents with Alzheimer's and most of the time had not worked at the facility long enough to know the residents. Interview with a fourth MA on 12/19/17 at 2:20pm revealed: -Resident #9 was "very combative with residents" and her behavior was unpredictable. -Staff would redirect Resident #9 most of the time to keep the resident out of other residents' rooms, but redirecting did not work. -Resident #9 was especially aggressive about her room or what she thought was her room. -Resident #9 had wandered into other resident rooms and thinking that it was her room, she would "jump on residents" who went into their own room. -Most of the incidents happened on 2nd and 3rd shift with Resident #9. Telephone interviews with Resident #9's PCP on 12/19/17 at 3:25pm and 12/20/17 at 2:22pm revealed:	D 270		

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D 270	Continued From page 39 -Resident #9 was territorial and highly provoked whenever another resident wandered into her space. -He was not aware of the details of the altercation on 12/4/17, but staff did notify him. -The incidents involving Resident #9 would probably have been more frequent if staff had not been trying, but the incidents were hard to prevent with the limited number of staff compared to the number of residents. -Resident #9 needed a short term behavioral health controlled environment and once stabilized would be okay for the SCU. -He felt the residents would benefit from more supervision. Attempted interview with Resident #9's MHP on 12/20/17 at 1:54pm was unsuccessful. Interview with the MCM on 12/20/17 at 2:49pm and 12/21/17 at 2:13pm revealed: -Resident #9's behavior had been more harmful to residents over the last one and half to two months. -Resident #9 had a concern for other residents getting into her personal space. -There were altercations between Resident #9 and other residents because residents were free to wander and Resident #9 was free to come out in the common areas. -She had communicated Resident #9's aggressive behavior to the PCP. -Staff implemented recommendations from the PCP to keep residents out of Resident #9's space. -Staff were expected to redirect residents who wandered into other residents' rooms or if a resident was being aggressive, report any incidents of aggression to the PCP, administer as needed medications, if they were ordered, and	D 270		

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D 270	Continued From page 40 document in the events. -Staff performed 15 minutes checks walking up and down the halls on the SCU. -There were staffing issues where there was not always enough staff on duty to supervise residents like Resident #9. Interview with the Administrator on 12/21/17 at 2:13pm revealed: -Resident #9 had had aggressive behaviors for approximately one year, and the behaviors had been occurring more frequently, but not with more severity, except the incident resulting in a resident having a fractured pelvis. -In addition to communicating with the PCP, staff also communicated with the family and there were medication changes. -If Resident #9 was out in the common areas, staff were in close proximity to supervise. -Increased supervision was on a case by case basis and Resident #9 was one of those cases. -Staff were expected to check Resident #9 frequently. -There was no set time frame for frequently and there was no documentation of checks. Refer to interview with a Medication Aide (MA) on 12/18/17 at 5:20pm. 2. Review of Resident #1's current FL2 dated 11/21/17 revealed: -Diagnoses included Alzheimer's dementia with behavioral disturbance, history of depression, syncope, coronary artery disease, controlled type II diabetes, hypertension, chronic kidney disease, and hyperlipidemia. -Resident #1 was constantly disisoriented. -She was nonverbal. -The resident wandered.	D 270		

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D 270	Continued From page 41 Review of Resident #1's Resident Register revealed the resident was admitted to the Special Care Unit (SCU) of the facility on 7/21/17. Review of the current care plan for Resident #1 dated 7/24/17 revealed: -Resident #1 wandered, had physically abusive behaviors, and was resistant to care. -Resident #1 was not receiving services and medications for behaviors/mental illness. -Extensive staff assistance was required for toileting, bathing, dressing, and grooming. -Limited staff assistance was required for ambulation and transfers. -The resident was always disoriented and had significant memory loss and must be directed by staff. Interview with Resident #1's guardian on 12/18/17 at 1:30 p.m. revealed: -He was pleased "pretty much" with Resident #1's care at the facility until the incident occurred on 10/28/17. -On 10/28/17, he was told by staff that Resident #1 went down the hallway of the SCU to the men's dining room area. -A male resident was found standing over Resident #1 with his pants down. -He wasn't sure how long Resident #1 had been down on the men's side of the SCU. -He wasn't sure how often Resident #1 was monitored, but she needed to be checked more often due to unsteadiness at times, falls, and mainly because of that incident on 10/28/17. -Resident #1 could not speak and had dementia. -She needed staff help and to be "checked on because she wasn't aware of her known name, where she was, or what she was doing." -Resident #1 had behaviors but "didn't have any more behaviors than the other residents."	D 270		

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D 270	Continued From page 42 -He had seen other residents be aggressive toward Resident #1 like she was toward them. -Resident #1 would grab, hit, throw things, or push others. -Sometimes, when he visited with Resident #1, staff were not around to help when behaviors occurred because they were other places in the SCU. Confidential Interview with a staff revealed: -Resident #1 roamed the hallway of the SCU daily. -She wandered in and out of other residents' rooms. -The resident was "very touchy" with other residents if they were close to her and she would put her hands on them. -She would grab other residents or pull on their clothes. -She hit other residents. -Resident #1 was nonverbal, disoriented, and did not socialize with other residents in the SCU. -She was monitored closely by staff every "30 minutes to an hour or so" because she would grab or pull on other residents and was a fall risk. -Resident #1 was observed by a staff in the men's hall dining room on 10/28/17 engaged in sexual behavior. -After the sexual incident on 10/28/17, involving Resident #1 and a male resident in the SCU, staff monitoring was increased to 15 minute checks for Resident #1. -It was difficult to monitor Resident #1 every 15-minutes from all areas of the SCU because the dining rooms and living room areas were not visible from the main hallway. -Sometimes Resident #1 was found on the floor by staff in the areas of the SCU that were not easily seen from the main hallway of the unit.	D 270		

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D 270	Continued From page 43 Observation of the SCU female residents' dining room area on 12/13/17 from 11:45 a.m. through 12:35 p.m. revealed: -There were 10-12 residents seated at the dining room tables without food or beverages, while Resident #1 and two other female residents walked back and forth. -There were no staff in the dining room area from 11:45a.m. until 12:35 p.m. Observation of Resident #1 on 12/14/17 from 9:15 a.m. through 9:38 a.m. revealed: -The resident was walking up and down the main hallway of the SCU. -She went in and out of three residents' rooms. -There were no staff on the hall. A. Review of electronic charting notes for Resident #1 dated 7/21/17 through 11/28/17 revealed: -On 7/21/17 at 9:51 p.m., Resident #1 got into a physical altercation with another female resident; no injuries occurred. -On 7/22/17 at 6:29 p.m., Resident #1 became combative with another resident, struck the other resident twice in the face with provocation and tore the closet door off its track in her room. -On 7/29/17 at 10:39 p.m., Resident #1 became combative during the evening meal, threw drinks on the floor and onto other residents; did not like to stay still for meals and was not cooperative at all. -On 9/05/17 at 11:04 p.m., no change was noted in the resident's behavior after she returned from the hospital. Resident #1 had to be separated from the other residents at mealtime because she tried to take the other residents' food and drink. Resident #1 continued to walk up and down hallway and entered other residents' rooms and removed items.	D 270		

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D 270	Continued From page 44 -On 9/07/17 at 11:02 p.m., Resident #1 had to be separated from another resident at dinner because she tried to take another resident's food and drink. -On 9/08/17 at 2:21 p.m., Resident #1 ate all meals, but had to sit alone so she didn't take residents' food. -On 9/29/17 at 1:36 p.m., Resident #1 seemed to be agitated; pulled and grabbed on residents and would not sit down or listen. -On 10/24/17 at 2:26 p.m., Resident #1 was involved in two altercations today; struck another resident across the head with a bowling pin and then, went to the dining area and dragged another resident out of her chair, causing that resident to be transported to the hospital by Emergency Medical Service (EMS). -On 10/26/17 at 2:36 p.m., Resident #1 was putting her hands in other residents' plates, took their drinks, and tried to hit staff. Interview with a Personal Care Aide (PCA) on 12/13/17 at 12:47 p.m. revealed: -Resident #1 walked the hallway and went in and out of other resident rooms. -Staff checked on the residents, including Resident #1, every one to two hours. -Resident #1 would reach out and grab other residents at times. -She would hit at other residents. -She was confused and didn't know what she was doing because of her dementia. -Resident #1 needed to be monitored closely but because she walked the halls; it wasn't easy to check her as often. Interview with a Medication Aide (MA) on 12/18/17 at 5:20 p.m. revealed: -Resident #1 had to be monitored "all of the time" because of her behaviors of touching and hitting	D 270		

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other residents.
-Resident #1 was in a locked unit so she thought it was okay for the resident to roam the halls.
-Resident #1 would would take other residents' food and drink from their plates even after she had eaten.
-Staff would take her from the table because she would take food from other residents.
-Resident #1 would fight other residents and staff "all of the time."

Interview with Resident #1's primary care physician (PCP) on 12/21/17 at 11:40 p.m. revealed:
-Resident #1 was admitted July of 2017 to the facility SCU.
-She knew Resident #1 for years prior to her decline and admission to the facility.
-The resident should be monitored closely by staff because of her cognitive/ mental status.
-She was aware Resident #1 had behaviors and was aggressive toward others.
-There had been no medication changes to address behaviors or aggression.

Interview with the Memory Care Manager (MCM) on 12/19/17 at 11:00 a.m. revealed she was aware Resident #1 had behaviors, but not aggressive behaviors.

Interview with the Administrator on 12/20/17 at 3:45 p.m. revealed he was unaware of Resident #1 having aggressive behaviors toward others.

B. Review of electronic charting notes for Resident #1 dated 9/01/17 through 11/26/17 revealed:
-On 9/01/17 at 9:15 p.m., Resident #1's nose was very swollen; unusually swollen.
-On 9/02/17 at 9:41 p.m., Resident #1 had a

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swollen nose on 9/01/17 and on that day, when staff came in at 7:00 p.m., Resident #1 had a black eye. Resident #1 acted fine and continued to walk around.
-There was no documnetation of what happened to Resident #1's nose or eye.
-On 9/04/17 at 1:15 p.m., Resident #1 was observed on the floor face down at 8:30 a.m. She was sent to the emergency room.
-On 9/05/17 at 2:25 p.m., Resident #1 returned from the hospital with stitches over her left eye.
-On 11/10/17 at 6:59 p.m., late entry, Resident #1 was found on the floor in another resident's room with that resident standing over her.
-On 11/26/17 at 8:37 a.m., Resident #1 was observed laying on the floor in the dayroom.

Review of an Accident/Injury Reports dated 9/04/17 for Resident #1 revealed on 9/04/17 at 8:30 a.m., Resident #1 was found on the floor face down with swelling and an abrasion noted to the "eye area."

Attempted interviews on 12/14/17 at 6:25 p.m. and 12/15/17 at 1:56 p.m., with the staff who completed the Accident/Injury report dated 9/04/17 for Resident #1, were unsuccessful.

Review of an Accident/Injury Reports dated 11/26/17 for Resident #1 revealed on 11/26/17, at 8:37 a.m., Resident #1 was observed laying in the dayroom on the floor. No injury.

Interview with a second PCA on 12/13/17 at 4:30 p.m. revealed:
-Resident #1 was monitored more closely to prevent falls because she stumbled at times.
-Resident #1 wandered up and down the halls of the SCU and went into other residents' rooms.
-She checked on all of the SCU residents,

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D 270	Continued From page 47 including Resident #1, every 2 hours. Interview with Resident #1's PCP on 12/21/17 at 11:40 p.m. revealed: -She was not aware of an incident involving another resident standing over Resident #1 that was noted on 11/10/17. -She was not made aware of incidents of falls involving Resident #1. -There was no documentation in their system regarding the incident of another resident standing over Resident #1. There was no documentation provided to indicate the primary physician and the guardian/family were notified of incidents of Resident #1 being found on the floor as a result of a fall (9/04/17) or an incident involving Resident #1 on the floor with a resident standing over her (11/10/17). C. Review of an electronic charting note for Resident #1 dated10/28/17 revealed: -On 10/28/17 at 6:38 p.m., Resident #1 was observed by a staff member "engaged in sexual behavior" with another resident and staff would continue to monitor. Review of an Accident/Injury Report dated 10/28/17 at 9:45am for Resident #1 revealed: -Staff documented "sexual behavior noticed." -The incident occurred in the dining room and was witnessed by staff. Interview with a second PCA on 12/13/17 at 4:30 p.m. revealed after an incident near the end of October 2017 (a sexual incident on 10/28/17), Resident #1 was placed on 15 minute checks. Interview with a Medication Aide (MA) on 12/18/17 at 5:20 p.m. revealed "eyes were to be	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R-C 12/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

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D 270	Continued From page 48 kept on her (Resident #1), but after the 10/28/17 sexual incident, staff were asked to monitor her (Resident #1) more closely at all times." Interview with Resident #1's PCP on 12/21/17 at 11:40 p.m. revealed: -Resident #1 could not consent to particiapte in a sexual act due to her diagnoses. -She was not made aware of the sexual incident involving Resident #1 that occured on 10/28/17. Interview with the Memory Care Manager (MCM) on 12/19/17 at 11:00 a.m. revealed: -The SCU staff called her following the sexual encounter between two residents on 10/28/17 and asked what to do. -The MCM informed the facility staff that she was unsure of what to do and she would call the facility staff back. -Resident #1 went to the men's hall on the day of the incident (10/28/17). -The MCM was unsure of when Resident #1 had last been checked by staff or how long she had been down on that end of the hall but the incident on 10/28/17 "probably only lasted three minutes." -Following the incident on 10/28/17, Resident #1 was immediately separated from the male resident and she was placed on 15 minute checks. Interview with the Administrator on 12/20/17 at 3:45 p.m. revealed: -Resident #1 was monitored closely due to being at risk for falls and as a result of an incident on 10/28/17. -On 10/28/17, Resident #1 was found by staff "engaging in a sexual act" with a male resident on the SCU. -He was told Resident #1 was seated in the male's dining room at the table and a male	D 270		

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D 270	Continued From page 49 resident was standing beside her with his penis exposed. -The male resident's semen was on Resident #1's blouse, face, and hair and also on the male resident's pants. -"Resident #1 drooled and some or all of the substance observed may have been her drool." -There were no signs of harm and Resident #1 was placed on 15 minute checks. Based on observations, interviews, and record reviews, Resident #1 was not interviewable. Confidential interview with a second staff revealed: -Resident #1 normally walked the halls of the SCU. -Most of the time, staff were attending to the residents the best they could and were not able to be on the halls. -Resident #1 was unsupervised by staff most of the time because staff were busy in the bathrooms or dining rooms of the SCU. -The SCU was a locked unit and it was okay for residents to roam the halls. Interview with a Medication Aide (MA) on 12/18/17 at 5:20 p.m. revealed: -Resident #1 had to be monitored "all of the time" because of her behaviors of touching and hitting other residents. -Resident #1 was in a locked unit so she thought it was okay for the resident to roam the halls. -Resident #1 would would take other residents' food and drink from their plates even after she had eaten. -Staff would take her from the table because she would take food from other residents. -Resident #1 would fight other residents and staff "all of the time."	D 270		

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D 270	Continued From page 50 Interview with a second MA on 12/19/17 at 11:45 a.m. revealed: -Resident #1 walked into other residents' rooms on the SCU. -The resident would grab other residents' food even after she had just eaten all of her food. -She was asked by other staff to help calm Resident #1 down when the resident was upset. Interview with a third MA on 12/19/17 at 2:45 p.m. revealed: -All residents were checked every 30 minutes to an hour in the SCU. -Resident #1 was checked every 15 minutes because her behaviors bothered other residents. -Resident #1 was not monitored every 15 minutes, because of her behaviors, but "more so to protect others." -She would redirect Resident #1 when these behaviors occurred. -She would redirect Resident #1 by walking with her up and down the halls of the SCU and by talking to her. -When behaviors occurred on the SCU, there were no supervision changes; staff redirected the residents' behaviors. Interview with Resident #1's PCP on 12/21/17 at 11:40 p.m. revealed: -Resident #1 was admitted July of 2017 to the facility SCU. -She knew Resident #1 for years prior to her decline and admission to the facility. -The resident should be monitored closely by staff because of her cognitive/ mental status. Interview with the Memory Care Manager (MCM) on 12/19/17 at 11:00 a.m. revealed: -All residents on the SCU were monitored	D 270		

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D 270	Continued From page 51 differently. -Some residents required more supervision and were monitored more closely than others. -All residents on the SCU could walk around freely because it was a locked unit. -Residents on the SCU were monitored every 2 hours for toileting. -SCU staff monitored the halls every 15 minutes and "laid eyes" on every resident, including Resident #1, at least every 30 minutes. -Resident #1 wandered the halls in the SCU daily. Interview with the Administrator on 12/20/17 at 3:45 p.m. revealed: -All residents in the SCU were monitored by staff at least every 2 hours unless their plans required more supervision. -Those residents who were fall risks were monitored more closely by staff, but he was unaware of how often. Interview with, the MCM and the Administrator on 12/21/17 at 2:45 p.m. revealed: -No one saw what happened on the men's side of the SCU in the dining room between Resident #1 and a male resident. -No one knew how long Resident #1 was down there, "it couldn't have been more than five minutes." -Staff in the SCU monitored all residents according to their specified needs. -Resident #1 had to have been checked on by staff within 15 minutes as required for her. -There were no specified timeframes for residents who engaged in behaviors. -Residents, including Resident #1, who engaged in any aggressive behaviors were monitored closely until calm. There was no documentation of Resident #1's 15	D 270		

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D 270	Continued From page 52 minute checks provided prior to survey exit. Refer to interview with a Medication Aide (MA) on 12/18/17 at 5:20pm. 3.Review of Resident #2's current FL-2 dated 3/29/17 revealed: -Diagnoses included Alzheimer's dementia and hypertension. -Resident #2 was intermittently disoriented. Review of Resident #2's current Care Plan dated 8/25/17 revealed: -Resident #2 was sometimes disoriented. -Resident #2 was forgetful and needed reminders. Review of Resident #2's physician's note dated 10/26/17 revealed: -"Patient has been displaying increased sexual arousal acutely" -Because Resident #2 and the female resident had a diagnosis of Dementia, it could not be determined if the sex was consensual. -Resident #2 denied any recollection of a relationship with another resident. -"I will change patient's Mirtazapine to Paroxetine." Review of the accident/injury report dated 10/28/17 for Resident #2 revealed -A" sexual behavior was noticed" in the male dining room. -The incident occurred on 10/28/17 at 9:45 a.m. Review of the electronic charting notes for Resident #2 dated 10/28/17 at 6:38 p.m. revealed Resident #2 was engaged in a sexual behavior with another resident.	D 270		

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D 270	Continued From page 53 Review of a physician's order dated 10/29/17 for Resident #2 revealed: -There was a medication order to discontinue Mirtazapine 7.5 mg every hour of sleep as of 10/29/17. (Mirtazapine is used to treat depression and insomnia; and does not have a significant effect on sexual arousal). -There was a medication order to begin Paroxetine 20 mg 1 tablet daily on 10/30/17 (Paroxetine is used to treat depression and reduces the desire for sexual arousal). Review of a physician's order dated 11/2/17 for Resident #2 revealed: -There was a medication order to discontinue Paroxetine 20 mg 1 tablet daily. -There was a medication order to start Paroxetine 40 mg tablet daily. Interview with a housekeeper on 12/15/17 at 9:30 a.m. revealed: -He found Resident #2 and female resident in the male dining room. -Resident #2 was standing on the right side of the female resident, and he was touching her chest over her clothing. -The female resident was sitting in a chair pushed up to the table. -The incident happened before lunch, but he could not recall the date or time, and it may have been a weekend." -He found the medication aide (MA) in the hallway and just pointed toward the dining room. -He did not go with the MA to the dining room. -The housekeeper was not asked any questions about the incident, and he was not asked to write a statement about the incident. Interview with a MA on 12/14/17 at 4:30 p.m. revealed:	D 270		

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D 270	Continued From page 54 -Resident #2 attempted to lure female residents into his room daily from June 2017 to October 2017. -On 10/28/17, the housekeeper stated he needed to go to the male dining room. -No more information was given. -He found a female resident sitting in a chair about 6 inches from the dining room table. -He found Resident #2 standing on the right side of the female resident. -Resident #2's penis was "exposed", and fluid was coming from his penis. -Resident #2 was rubbing the female resident's back with his left hand and stroking the side of her face with his right hand. -The female resident had a wet area on the upper third part of her blouse. -It could not be determined if the fluid was drool from breakfast or semen from the penis. -The female resident showed no type of emotion or emotional distress. -The supervisor was notified at 10:00 a.m. on 10/28/17, and she did not know how to handle the incident. -The Memory Care Manager (MCM) was called at 10:15 a.m., and she stated, "She would call me back." -The MCM came to the facility at 11:00 a.m. on 10/28/17. -She instructed staff to do one to one with both residents. -Resident #2 and the female resident's clothes were shown to the MCM. -The clothes had not been washed and the MCM took over the investigation. -The MA notified Resident #2's Primary Care Physician (PCP) on 10/28/17 at 5:50 p.m. of the incident between Resident #2 and a female resident.	D 270		

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D 270	Continued From page 55 Interview with a personal care aide (PCA) on 12/19/17 at 10:22 a.m. revealed: -Resident #2 would attempt to grab and pull female residents into his room at least weekly after lunch. -Resident #2 had a habit of staying in the men's dining room and looking out the window after meals. -Resident #2 grabbed a second female resident and pulled her in his room. -Resident #2 and this female resident were found sitting on the bed holding hands (no date or time), and they had their clothes on. -The incident had been reported to the MA and the MCM. -The PCA could not recall the date or time. -The MCM was aware Resident #2 attempted to grab women and pull them into his room. -Staff were told to keep an eye on Resident #2, but did not document how often they checked on Resident #2. -Staff were assigned to monitor the hallway to prevent Resident #2 from grabbing and pulling female residents into his room. -Resident #2 was not supposed to have any women in his room. -She was aware of the sexual encounter which occurred on 10/28/17 after breakfast between Resident #2 and a female resident. -She was instructed by the MA on 10/28/17 (no time) to go to the men's dining room. -She found Resident #2 standing at the right side of the female resident. -Resident #2 had a "quarter size wet spot" at the base of the fly of his pants. -The female resident had a "less than quarter size wet spot" on the top of her shirt. -The female resident was sitting in a chair pushed up to the table. -She was instructed by the MCM to monitor both	D 270		

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D 270	Continued From page 56 residents every 15 minutes, but did not document the 15 minutes checks. -She was instructed by the MCM to wash both residents' clothing. Interview with a second PCA on 12/19/17 at 10:45 a.m. revealed: -The MCM told the staff to keep an eye on Resident #2, but no specific time frame was given. -Resident #2 had a habit of luring female residents into his room. -Resident #2 was not allowed to come to the women's end of the unit. -She was aware of a sexual encounter which occurred on 10/28/17 between Resident #2 and a female resident, and Resident #2 had a wet spot on the front of his pants. -She did not witness the sexual encounter on 10/28/17. -She was instructed by the MA on 10/28/17 (no time) to go to the men's dining room. -The female resident had a wet spot on the top of her blouse and the right arm of the chair. -A (quarter-sized) puddle of fluid was on the floor beside the dining room chair. -Clothes were put in the laundry room to be washed. Telephone interview with Resident #2's PCP on 12/18/17 at 4:22 p.m. revealed: -He was notified of the sexual encounter which took place between Resident #2 and female resident on 10/28/17. -Resident #2 had been displaying increased sexual arousal. -He had changed Mirtazapine to Paroxetine on 10/26/17. -There should be increased supervision for Resident #2 and the other female resident.	D 270		

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D 270	Continued From page 57 -The staff needed more training on how to deal with residents that have a diagnosis of Dementia. On 12/18/17 at 4:00 p.m., Resident #2 was confused and did not seem to understand what was being asked of him during the interview. Attempted interview with Resident #2's family member on 12/18/17 at 4:12 p.m. was unsuccessful. Interview with the MCM on 12/13/17 at 12:45 p.m. revealed: -Resident #2 had shown increased signs of sexual behavior more than six weeks ago, prior to the incident on 10/28/17. -He had tried to get women into his room, because he was aroused. -Staff had seen a second female resident laying on top of the bed covers of Resident #2's bed and holding hands with Resident #2, but they were fully clothed. -She did not know the date or time. -Staff had also seen a third female resident on the top of the bed covers of Resident #2's bed and holding hands with Resident #2, but they were fully clothed. -She did not know the date or time. -These incidents were not documented. -Resident #2 was already on medication to decrease sexual arousal. -Resident #2 was on 15 minutes checks until he was seen by his physician on 11/2/17. -The MA notified MCM about the sexual encounter between Resident #2 and the female resident, but she could not recall the date or time, and the staff had already changed Resident #2 and the female resident's clothes. -The laundry staff had just washed their clothes -A conclusion could be drawn that there was a	D 270		

Division of Health Service Regulation

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D 270	Continued From page 58 sexual encounter between Resident #2 and a female resident, based on the amount of fluid present without seeing the clothing. -She instructed the staff to "keep an eye" on Resident #2 and a female resident, but no specific time frame was given. -She talked to the staff and residents, and there was no witness to the sexual encounter between Resident #2 and the female resident. -She notified the Administrator on 10/28/17 (no time) that a sexual encounter had occurred between Resident #2 and a female resident. -The Administrator instructed her to "check for signs of sexual non-consent and force." Interview with the Administrator on 12/21/17 at 5:30 p.m. revealed: -He was notified by the MCM on 10/28/17 (no time) that Resident #2 and a female resident had a sexual encounter. -Neither resident was not able to give consent because of their dementia. -He did not know that Resident #2 had a history of luring female residents in his room before the sexual encounter on 10/28/17. -If the Administrator had known, he would have communicated with Resident #2's physician about Resident #2 luring female residents into his room. Refer to interview with a Medication Aide (MA) on 12/18/17 at 5:20pm. Interview with a MA on 12/18/17 at 5:20pm revealed: -For residents with behavior issues, staff would involve the resident in activity for distraction or provide a snack. -Some residents were taken in the day room and some residents would walk the halls during 1st and 2nd shift.	D 270		

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D 270	Continued From page 59 -There was one PCA in the day room, one PCA on the hallways and two PCAs would be giving residents showers. -Most of the PCAs "just wanted to go ahead and give their showers," but she would tell the PCAs "someone had to be on the floor." _____ The facility's failure to supervise Resident #9 who was known to have physically aggressive behaviors resulted in 15 incidents of assault toward eight other residents causing a pelvic fracture for one of the residents; and Resident #2 who was known to have sexually aggressive behaviors which resulted in an incident of sexual assault of another resident. This noncompliance constitutes a Type A1 Violation for serious physical harm and neglect._____ Review of the Plan of Protection submitted by the facility on 12/14/17 revealed: -Immediately staff will be in-serviced on systems process including fall management program, rounding and hot box process as well as redirecting when behaviors occur. -Starting 12/14/17, mood/behavior monitoring and communications form will be implemented to identify and monitor interventions. -When a behavior occurs, staff will identify root cause to determine most effective intervention. -Resident interventions vary and each resident shall be considered case by case. -The Primary Care Provider (PCP) is notified of behaviors and referral for psychiatric services is given for a licensed provider to determine best interventions. -Community Supervisors will implement [interventions] based on need and recommendations. -Residents are identified with falls by following the fall management program.	D 270		

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D 270	Continued From page 60 -System process will be reviewed upon hire (for new staff) during orientation by the Executive Director (ED) or Designee. -Annual (and as needed) training will be conducted by the ED. -The ED and Care Manager (CM) will monitor systems through random audits, observations and interviews. -An in-service is scheduled for 12/22/17 by the Registered Nurse (RN) for resident interventions. -Upon admission, all residents will be put on 72 hour hot box [monitoring] for observation and to establish a baseline. -When a behavior is identified, it will be documented in the mood/behavior and communication binders, supervision will be increased, and care staff will notify Management and the PCP. -Any behavior which escalates to a threat to a resident or others, shall require immediate intervention (move resident out of harm's way and call 911) to assure the safety. -A fall risk assessment will be completed for all new residents. -A monthly fall management meeting will be completed to identify at risk residents. -Residents diagnosis, history and physical will be reviewed prior to admission and [preventative] interventions will include redirecting, providing snacks and [administering] as needed medications. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 20, 2018.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care	D 273		

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D 273	Continued From page 61 (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Type B Violation: Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider for 2 of 2 sampled residents (#1, #8) related to the sexual assault of Resident #1 and the sexually expressive behaviors of Resident #8. The findings are: 1. Review of Resident #1's current FL2 dated 11/21/17 revealed: -Diagnoses included of Alzheimer's dementia with behavioral disturbance, history of depression, syncope, coronary artery disease, controlled type II diabetes, hypertension, chronic kidney disease, and hyperlipidemia. Review of Resident #1's Resident Register revealed the resident was admitted to the Special Care Unit (SCU) of the facility on 7/21/17. Review of the current care plan for Resident #1 dated 7/24/17 revealed: -Resident #1 wandered, had physically abusive behaviors and was resistant to care. -Resident #1 was not receiving services and medications for behaviors/mental illness. -Extensive staff assistance was required for toileting, bathing, dressing, and grooming. -Limited staff assistance was required for	D 273	Facility has audited all resident records on 1/3/18 and 1/4/18 to determine any outstanding issues which included butnot limited to, diet orders, physicianorders, FL2, and Dr. appointments requiring notification and follow-up with Phyisician. All issues identified will be reported and followed-up immediately. ED and CM will review 24hour communication log on daily basis to ensure all issues have been reported to Physician for appropriate follow-up. 12/22/17 RN conducted in-service training regarding 24 hour shift log process. CM will conduct weekly chart audit. ED will monitor chart audit process to ensure completion and ongoing compliance. Plan of correction date is 2/4/18.	

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D 273	Continued From page 62 ambulation and transfer. -Resident #1 had significant loss of memory and needed direction from staff. -The resident was always disoriented. Review of electronic charting notes for Resident #1 dated 10/28/17 through 11/10/17 revealed: -On 10/28/17 at 6:38 p.m., Resident #1 observed by staff "engaged in sexual behavior" with another resident and staff will continue to monitor. -On 10/29/17 at 6:42 p.m., Resident #1 was kept under "extra supervision" during entire shift. No new incidents. -On 10/30/17 at 10:23 p.m., the resident was kept "under supervision" during shift. No sexual behavior noticed. -On 11/10/17 at 6:59 p.m., late entry, Resident #1 was found on the floor in another resident's room with that resident standing over her. Interview with Resident #1's guardian on 12/18/17 at 1:30 p.m. revealed: -He had been pleased "pretty much" with Resident #1's care at the facility until the incident occurred on 10/28/17. -On 10/28/17, the guardian was told by staff that Resident #1 went down the hallway of the SCU to the men's dining room area. -A male resident was found standing over Resident #1 with his pants down. -"There was semen on Resident #1's blouse." -"I was very upset because no one called me until after 6:00 p.m. on 10/28/17, but the incident had happened that morning." -The staff person who had called him left "very little information" on his answering machine and was speaking in a "low tone of voice" and was "very vague." -He called the facility to find out what had happened to Resident #1, but the staff still gave	D 273		

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D 273	Continued From page 63 unclear information. -Staff explained that they were tied up on the floor assisting other residents and could not call him earlier. -The guardian was told the Administrator would contact him and meet with him regarding the incident. -He couldn't understand why Resident #1 was not sent out to be examined after what had happened to her in the dining room. -After going home and talking with his family, the guardian shared Resident #1 should have been checked by a doctor because "we don't know what diseases the male resident may have had." -The Administrator contacted him on Thursday, 11/02/17, and he met with the Administrator on 11/03/17. -He didn't learn what had happened with Resident #1 until the meeting on 11/03/17 with the Administrator. -The Administrator shared what staff had told him on 10/28/17 on the short voice message and in person at the facility. -The Administrator told him that no one knew what actually happened between Resident #1 and the male resident, but there did not appear to be any physical signs of harm. -The guardian wanted to have been notified sooner of the incident and would have asked for Resident #1 to be checked by a doctor to make sure she was okay. -Since it had been almost a week since the incident, he did not request Resident #1 to be examined by a doctor. -The guardian had not been made aware of any other incidents regarding behaviors or falls involving Resident #1. Confidential Interview with a staff revealed: -Resident #1 was nonverbal, disoriented, and did	D 273		

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not socialize with other residents in the SCU.
-She was monitored closely by staff every "30 minutes to an hour or so" because she would grab or pull on other residents and was a fall risk.
-After the sexual incident on 10/28/17, involving Resident #1 and another resident in the SCU, staff monitoring was increased to 15 minute checks for Resident #1.
-It was difficult to monitor Resident #1 every 15 minutes from all areas of the SCU because the dining rooms and living room areas were not visible from the main hallway.
-Sometimes Resident #1 was found on the floor by staff in those areas of the SCU that were not visible from the main hallway.
-Staff notified the Medication Aides (MAs) of all falls or behavior incidents on the SCU.

Interview with a nurse on call for Resident #1's primary care physician's (PCP's) office on 12/19/17 at 2:45 p.m. revealed:
-Resident #1 was nonverbal and "severely" disoriented.
-She resided in the SCU at the facility.
-According to the notes she reviewed for Resident #1, the PCP's office had not been notified of any sexual incidents or falls.
-She did not have any other information regarding Resident #1.

Interview with Resident #1's PCP on 12/21/17 at 11:40 p.m. revealed:
-Resident #1 was admitted July 2017 to the facility SCU.
-She knew Resident #1 for years prior to her decline and admission to the facility.
-She was aware Resident #1 had behaviors and was aggressive toward others at times.
-She had not been informed of the incident involving Resident #1 and a male resident that

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D 273	Continued From page 65 occurred on 10/28/17. -She would have wanted to be notified of that incident on 10/28/17 because it was of sexual nature. -Resident #1 could not give consent to participate in any type of sexual activity due to her cognitive status. -She was not aware of an incident involving another resident standing over Resident #1 that was noted on 11/10/17. -She was not made aware of incidents of falls involving Resident #1. -There was no documentation in their system regarding the incident of another resident standing over Resident #1 or of the sexual encounter involving Resident #1. Based on observations, interviews, and record reviews, Resident #1 was not interviewable. Interview with the Memory Care Manager (MCM) on 12/19/17 at 11:00 a.m. revealed: -She was not sure if the PCP had been notified of the incident on 10/28/17 involving Resident #1 and a male resident. -There were no signs of a sexual assault or harm to Resident #1. -The sexual encounter was consentual. -Per staff reports of the sexual encounter that occurred on 10/28/17, Resident #1 had engaged in a "sexual act." -Both Resident #1 and the male resident's records were reviewed and no communicable diseases were noted; an incident report was not completed and the PCP was not notified. Interview with the Administrator on 12/20/17 at 3:45 p.m. revealed: -The PCP was not notified regarding the sexual incident on 10/28/17 because he believed it was	D 273		

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D 273	Continued From page 66 "consensual and the residents' right to have sex." -Resident #1 did not appear to have been assaulted. -The semen found on Resident #1's face and blouse and on the male resident's pants may have been some of Resident #1's drool, but he was not sure. -There was no facility policy on addressing sexual behaviors between residents, but the situation was addressed by separating the two residents and placing Resident #1 on 15-minute checks. There was no documentation provided to indicate the primary physician and the guardian/family was notified of incidents of Resident #1 being found on the floor as a result of a fall and of the sexual assault incident of Resident #1 prior to survey exit. 2. Review of Resident #8's current FL-2 dated 6/29/17 revealed: -Diagnoses included Alzheimer's Disease, chronic nausea and chronic abdominal pain. -There resident was intermittently disoriented, ambulatory and hard of hearing. -The resident's current level of care was assisted living. -The recommended level of care was the Special Care Unit (SCU). Review of Resident #8's prior FL-2 dated 5/15/17 revealed: -Diagnoses included Alzheimer's Disease, chronic nausea and chronic abdominal pain. -The resident was intermittently disoriented, ambulatory and hard of hearing. -The resident's current level of care and the recommended level of care was assisted living. Review of Resident #8's Resident Register	D 273		

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D 273	Continued From page 67 revealed: -The resident was admitted to the facility on 5/10/17. -The resident was discharged from the facility on 9/7/17 to move to "own residence." Review of Resident #8's progress notes revealed: -There was an entry dated 6/28/17 at 10:10 p.m. by a staff documented the resident returned from the hospital with a diagnosis of dementia without behavioral disturbance. -There was an entry dated 7/7/17 at 2:45 p.m. by a staff that documented the resident moved to the SCU on 7/7//17 at 1:30 p.m. -There was an entry dated 7/15/17 at 10:16 p.m. by a staff that documented the resident was trying to "persuade" female residents in his room. -There was an entry dated 7/26/17 at 10:24 p.m. by a staff that documented "the resident had offered female residents food and drink to come in his room." The resident locked the door and would not answer the aides when they were looking for a female resident. The Medication Aide (MA) had to unlock the door and escort the female resident" out of Resident #8's room. The MA notified the supervisor and the MA continued to monitor the resident. Confidential interview with a staff revealed: -Resident #8 had been known to offer female residents in the SCU snacks and a beverage in order to get them to come in his room. -Resident #8 lived in the assisted living and then moved to the SCU. Confidential interview with a second staff revealed: -Resident #8 had a lock on his door when he first moved to the SCU. -The staff did not know how long the lock stayed	D 273		

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D 273	Continued From page 68 on the resident's door. -Sometimes staff could not get inside of Resident #8's room, because the door was locked. -Staff had to get the Housekeeper to let them in Resident #8's room. Confidential interview with a third staff revealed: -In the SCU, the staff had to keep female residents out of Resident #8's room. -Resident #8 made sexual comments to female residents. -There were three residents, who had been found in his room. -Resident #8 told the staff he gave one resident snacks, when the resident came to his room. -The staff had never seen a female resident undressed in Resident #8's room. -One day, the staff found a resident laying in Resident #8's bed fully dressed; the other resident sometimes knew what was going on and sometimes she did not know what was going on. -The staff could not remember the dates of the incidents. -Another day, the staff saw another resident in Resident #8's room sitting in the rocking chair eating snacks; the other resident was incompetent and was in his room because of his snacks. -A third day, Resident #8 was observed standing in front of a third resident rubbing his private area against the resident. Both residents were dressed and standing. The other resident was incompetent and did not know what was going onThe staff was told of the incident by another staff who no longer worked at the facility. -When residents were found in Resident #8's room, the staff reported it to a Supervisor. -Resident #8 was a "flirt." -The staff did not know if Resident #8 had changes in his medications to help control his	D 273		

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D 273	Continued From page 69 behaviors. -Resident #8 knew what he was doing. He was taking advantage of the residents. -If staff could not find a female resident, the first room they thought to look in was Resident #8's room. -The female residents were not always in Resident #8's room. Confidential interview with a fourth staff revealed: -Resident #8 had other residents in his room talking to him. -The staff had never known him to have inappropriate behaviors with other residents. -When the resident was first transferred to the SCU, there was a lock on his door, because the resident did not want anyone coming in his room. -The lock was taken off the door within the first week the resident was in the SCU, because locks were not allowed at the facility. -Resident #8 mainly stayed in his room. Confidential interview with a fifth staff revealed: -Resident #8 was not on any medications for behaviors. -When Resident #8 was in the SCU, a resident was found in Resident #8's room two weeks before he was discharged sitting in a chair drinking a soda or eating cookies. -One day, a resident was in Resident #8's room and the resident's family member got the resident out of Resident #8's room. -When residents were found in Resident #8's room, the staff reported it to a Supervisor. -"Resident #8 knew what he was doing." Confidential interview with a sixth staff revealed: -It was reported to the staff during first shift mid August 2017, a resident was found in Resident #8's room with her shirt improperly on her.	D 273		

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D 273	Continued From page 70 -The staff reported it to management and management said there was nothing that could be done. -When Resident #8 had inappropriate behaviors to other residents, management did not do anything. -The staff did not think Resident #8's primary care physician (PCP) had been contacted about Resident #8's behaviors. -Resident #8 did not have any changes in medications nor was the resident on medications for behaviors. -When Resident #8 had a female resident in his room, he always locked his door. Confidential interview with a seventh staff revealed: -When Resident #8 was living in the assisted living side of the facility, he tried to get female residents to come to his room. -The staff could not remember if they reported Resident #8's behaviors of trying to get female residents to come in his room to management or not. Confidential interview with a eighth staff revealed: -When Resident #8 lived in the assisted living side of the facility, he pushed female residents down the hall and tried to get the female residents to come to his room. -One day a couple of weeks after he came to the facility, he tried to get a resident to come in his room. The resident refused and reported it to the staff. The staff reported it to a Supervisor. -The resident who reported the incident told staff they were scared of Resident #8. Confidential interview with a resident revealed: -The resident lived in the assisted living side of the facility.	D 273		

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D 273	Continued From page 71 -One day Resident #8 tried to get the resident to come to his room. -Resident #8 told the resident his private area was excited about seeing the resident. -Resident #8 did not touch the resident. -The resident was afraid of Resident #8. -The resident never went to Resident #8's room. -The resident thought maybe Resident #8 would try to do something sexually to the resident. -The resident reported the incident to a staff. -The staff came and talked to Resident #8. -Resident #8 invited the resident to his room several times after that incident, but he finally stopped inviting the resident after the resident refused several times. -The resident could not remember when Resident #8 stopped inviting the resident to his room. -The resident could not remember the dates of the incident or where it occurred. Telephone interview with a resident's family member on 12/18/17 at 4:14 p.m. revealed: -The staff notified her that the resident was found lying on top of the bed covers of another resident. -She did not know the date or time. -She did not have any concerns about the resident's care at the facility. Interview with another resident's POA on 12/19/17 at 11:05 a.m. revealed: -Sometimes the resident would be found in other residents rooms laying in the bed, because she was confused. -One day during the fall on 2017, the resident was going through changes with her medications and was found sitting in a chair in Resident #8's room drinking a soda. -The resident did not know where she was located. She was confused. -Another day, the POA came to the facility to see	D 273		

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the resident.
-The POA could not find the resident.
-Staff started searching in each resident's room and found the resident in Resident #8's room sitting in a chair.
-Resident #8's door was locked.

Attempted interview with Resident #8's PCP on 12/18/17 at 2:05 p.m. was unsuccessful.

Telephone interview with Resident #8's PCP's nurse on 12/18/17 at 4:40 p.m. revealed:
-Resident #8 was discharged from the facility in September 2017, because the resident wanted to be at home.
-She did not know if the the resident had behavior problems or not.
-There was no documentation of behavior problems in Resident #8's record and the resident was not on any medications for behavior problems.
-If the resident had behavior problems, she was sure the PCP would have wanted to know about it.

Review of Resident #8's PCP notes revealed there was no documentation of sexually expressive behaviors.

Interview with the Memory Care Coordinator (MCM) on 12/20/17 at 2:50 p.m. revealed:
-Resident #8 was forgetful and hard of hearing.
-Resident #8 stayed in his room a lot in the SCU.
-The residents liked going to his room to eat snacks.
-He never forced anyone in his room.
-There was a time when a female resident was found in Resident #8's bed.
-The resident thought she was in her room.
-She could not remember if Resident #8 touched

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D 273	Continued From page 73 any residents inappropriately and had any sexual behaviors towards residents. -She was not sure if the PCP was aware of Resident #8's behaviors. -She delegated a MA to contact the resident's PCP if needed. -The behaviors were communicated verbally during stand up daily or weekly to staff. -The Administrator was aware of Resident #8's behaviors. Interview with the Administrator on 12/20/17 at 2:10 p.m. revealed: -If a resident had inappropriate behaviors with other residents, the facility communicated with the PCP, the resident's family members and increased checks more frequently on the resident. -Resident #8 was hard of hearing and forgetful. -Resident #8 flirted with female residents in the facility. -Staff kept a "close eye" on Resident #8. -In the SCU, he had women coming to his room. -Residents went in his room and got food. -The residents should not have been going into Resident #8's room. -Resident #8 had a private lock on his door, because his family complained of his food and cups missing in his room. -The lock was on the door for one month, then it was removed, because he was told by corporate residents could not have locks on the doors. -He was aware residents would go in Resident #8's room and sit on his bed and chair. -When other residents went in his room, he told staff to redirect the residents out of his room. -He was not aware of Resident #8 doing inappropriate sexual behaviors towards one of three residents found in his room. -If he was aware, he would have notified the	D 273		

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D 273	Continued From page 74 residents' Responsible Parties and contacted the residents' PCP. -If staff knew Resident #8 was doing inappropriate behaviors to residents, they should have told the MCM and the resident's PCP. -He was not aware Resident #8 would try to get female residents in his room while living in the assisted living side of the facility. -If he would have known, he would have contacted Resident #8's POA and PCP. Based on observations, interviews and record review, the three residents found in Resident #8's room were not interviewable. Attempted interview with Resident #8's POA on 12/18/17 at 2:00 p.m. and on 12/21/17 at 9:24 a.m. was unsuccessful. The facility's failure to notify the primary care physician for Resident #8's sexually expressive behaviors resulted in the resident's persistent pursuing of female residents in the Special Care Unit, luring them to his room with snacks and out of sight from monitoring by staff without medical or psychiatric interventions for Resident #8's behaviors; and failed to notify the primary care physician for Resident #1's alleged sexual assault by another resident resulting in Resident #1 not receiving any follow up examination and/or care. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. Review of the Plan of Protection submitted by the facility on 12/20/17 revealed: -Facility will immediately begin auditing all residents records to determine any outstanding issues which may include, but are not limited to, diet orders, physician's orders, FL2's, and	D 273		

Division of Health Service Regulation

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D 273	Continued From page 75 doctor's appointments requiring notifications and follow-up with physicians. -All issues identified will be reported and followed up immediately. -ED, RCD, and MCM will review communication log on daily basis to ensure all issues have been reported to physician for appropriate follow-up. -12/22/17, RN will educate staff regarding 24-hour shift log process which will serve as training for staff. -RCD / CM will conduct weekly chart audit to ensure ongoing compliance. -ED will monitor chart audit process to ensure completion and ongoing compliance. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 4, 2018.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to keep food preparation and storage areas, including the food cart, 1 reach-in cooler, 1 walk-in cooler, 1 walk-in freezer, an ice machine, tea and beverage machines, kitchen walls, the stove/oven, and doors clean and free of contamination. The findings are:	D 282	ED met with staff to discuss job descriptions and duties expected. A deep clean schedule was implemented 12/14/17. BOM will monitor cleanliness weekly. ED will monitor through routine monitoring. Training to dietary staff on cleaness and expectations completed by 2/4/18.	

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D 282	Continued From page 76 Observation of the food cart on 12/13/17 at 12:40 p.m. revealed: -The cart was parked outside of the men's dining room in the Special Care Unit (SCU). -The inside bottom, front and side ledges of the food cart all had accumulated food, debris and crumbs, as well as spill marks. Observation of the outside of 2 kitchen doors on 12/13/17 at 4:08 p.m. revealed: -The door area above and around the handles on both doors was covered in brown and gray stains. -The metal kick plate at the bottom of both doors was covered in grime and streaks. Observation of the ice machine on 12/13/17 at 4:26 p.m. revealed: -The inside edge had a buildup of dust and grime. -The inside hinged area was covered with dust and a black substance. -The left outside of the unit was covered in dust and was splattered with a dried white substance. -The right outside of the unit was covered in dust with white dried drips running down the side. Observation of the tea machine on 12/13/17 at 4:27 p.m. revealed: -There was a build up of grime on the entire machine. -Approximately ¼ cup of loose sugar was laying beneath the machine. Observation of the metal beverage dispenser on 12/13/17 at 4:27 p.m. revealed: -There was a build up of grime on each side of the unit and in the crevices around the unit. -Dried food particles were scattered underneath the unit.	D 282		

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D 282	Continued From page 77 Observation of the walk-in cooler on 12/13/17 at 4:28 p.m. revealed: -The right outside of the cooler was covered in a build up of grime, and a white dried substance that was splattered over the entire lower half of the unit. -The door and handle were covered with a build up of grime. -The door gaskets were covered with a dark brown build up of grime. -The inside of the door was covered in a build up of grime. -On the inside left wall, a fan was covered with a build up of grime and dust. -The left-hand wall was covered in a white dried substance. -The left-hand corner of the floor had scattered black debris -The right-hand wall was covered in a build up of grime. -The metal wire shelving had a build up of a brown substance. -There were areas of rust on the metal shelves. -The floor around the legs of the shelving had a build up of grime. -There was a crumbled piece of brown paper laying on the floor of the unit. Observation of the food cart on 12/13/17 at 4:37 p.m. revealed: -The outside surface areas were covered with splatters and grime. -The crevices had a build up of grime. -The gaskets were coated in a brown dried substance. -The inside shelf was covered in a build up of a brown substance. -The inside of the door was covered in a build up of grime.	D 282		

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D 282	Continued From page 78 Observation of the walk-in freezer on 12/13/17 at 4:40 p.m. revealed: -There was a build up of dust and a white dried substance splattered on the outside front of the unit. -There was a build up of black grime on the floor at the back wall. Observation of the back wall by the back exit door on 12/13/17 at 4:42 p.m. revealed: -There was a large brown stain in the middle of the back exit door. -From the middle of the door to the bottom of the door, there were gray and black dry dirt stains throughout the door. -The bottom of the wall on the right side of the back exit door had brown, dry liquid stains. Observation of the dry storage area on 12/13/17 at 4:45 p.m. revealed: -There was a large blue tote with a lid sitting on the metal shelving. -The inside of the tote contained individually sealed coffee packs, a loose white substance spilled in the bottom, a crumbled rubber glove and 2 pieces of loose pink paper laying in the bottom. -A second blue tote had a white substance spilled in the bottom, a dish towel and 3 packs of lays individual potato chip bags. -A clear tote with a white lid was covered in dirt and crumbs of food. -The inside of the clear tote had a loose beige substance in the bottom, a can of spice and an individually wrapped oatmeal cookie. -One of four corners on the floor had a spoon and napkin on the floor and a build up brown stain. Observation of the stove and oven on 12/13/17 at 4:49 p.m. revealed:	D 282		

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D 282	Continued From page 79 -The outside of the stove was covered in a buildup of black grease. -The knobs were covered in a grease and grime. -The crevices were covered in grease, grime and crumbs. -The entire back wall of the stove was covered in a buildup of grime and grease. Observation of the reach-in cooler on 12/13/17 at 4:50 p.m. revealed: -The bottom of the cooler and the metal shelf had white and brown stains and trash. -The white wire shelving had multiple areas of exposed rust. Observation of the metal serving pan storage shelf on 12/13/17 at 4:52 p.m. revealed: -There were approximately 25 various sized serving pans turned upside down for storage. -The outside edge of the pans and shelf were scattered with dried food particles. -The outside edge of the pans had a built up burned on grime. Observation of the plate storage cart on 12/13/17 at 4:52 p.m. revealed the outside area was covered in a buildup of grime. Observation of the inside of the kitchen doors on 12/13/17 at 4:53 p.m. revealed: -There was an area 6 inches by 3 inches of peeling paint. -The area above the door handle was covered in brown and grey stains. -The door facing to the right of the door handle was covered in brown and grey stains. Observation of the walls and floors of the kitchen on 12/13/17 at 4:54 p.m. revealed: -The walls had multiple areas of dirt, splatters and	D 282		

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D 282	Continued From page 80. grime build up. -The floor behind by the dishwasher was covered with a build up of dirt and loose food particles. -From the middle of the wall to the floor on the right side of the prep sink were multiple streaks of light brown and white unknown substances. Interview with the Administrator on 12/13/17 at 10:55 a.m. revealed: -They had 3 dining rooms, 1 in the Assisted Living and 2 in the SCU. -They did not currently have a dietary manager. -The cook was the primary contact in the kitchen. Interview with a dietary aide on 12/14/17 at 11:18 a.m. revealed: -They were responsible for cleaning between meals. -They washed the dishes, cleaned the tables and mopped the kitchen, after every meal. -They swept out the walk in cooler and freezer once a week. -They swept the stock room every day. -The entire kitchen was mopped every day before they left. -They did not have a cleanup crew. -If the ice machine needed cleaning, they called the company that it was leased from. -The company that it was leased from was on site "about" 2 months ago. -They could wipe the outside of the ice machine. -Sometimes the cook would clean the ice machine. -The dish racks were washed when the dishes went through the dishwasher. -They did not wash the dish racks separately. -The stock person was responsible for cleaning the stock room and making sure the room was neat. -The stock person was supposed to wipe	D 282		

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D 282	Continued From page 81 everything off, make sure the old food was moved forward, throw things away and make sure there was nothing on the floor. -She was not aware the gaskets around the doors on the walk-in cooler and freezer needed to be cleaned. -She had never cleaned it before and was not sure who was supposed to clean it. -She had never cleaned the fan area of the walk-in cooler and felt it was probably the maintenance technician's job to do this. -They used water and sanitizer to wipe things down in the kitchen once a week. -The cook was responsible for cleaning the oven and cooking area. -She had never seen the oven be deep cleaned. -The stove had always looked like that. Observation of the food cart on 12/14/17 at 11:32 a.m. revealed: -The metal rack on the inside bottom of the cart had a build up of a brown substance. -The back inside of the cart had multiple white streaks. -The inside of the door had streaks of white and a buildup of grime. -The outside of the cart had a build-up of dirt and grime. -The gaskets around the door were covered in a build up of grime. Interview with a kitchen stock person on 12/14/17 at 11:55 a.m. revealed: -He swept and mopped every opportunity, "at least after every meal." -He spot cleaned the walls if he saw something that needed it. -He was supposed to wipe off the shelves but had not wiped off the shelves recently. -He did light dusting and felt they were relatively	D 282		

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D 282	Continued From page 82 clean. -He was responsible for cleaning the walk-in cooler and freezer. -He swept and mopped the cooler. -He had not swept and mopped today (12/14/17) because he was still putting away stock. -If he saw stains on the shelves, he would wipe them down. -He did not know when he had last wiped the shelves down. -He had not cleaned the gaskets. -He had not noticed there was a build up of grime on the doors or gaskets. -He did not know who was supposed to clean the doors and gaskets. -He did not know the gaskets were loose. -If anything was broken, he reported it to the Administrator. -He had not reported the loose gaskets to anyone. -They had a clean-up schedule but were very busy and "do the best we can." Interview with a second dietary aide on 12/18/17 at 10:45 a.m. revealed: -He was responsible for making drinks, putting fruit in bowls and assisting the cook if needed. -He mopped the floors after every meal and when he could especially around the dishwasher. -He cleaned the dining room and the tables and swept the floor. -He would sweep the floors in the walk-in coolers and stock room 1-2 times per week. -He did not recall what day he had swept last, "one day last week." -They didn't usually clean the ice machine because it was leased and anything that was leased was cleaned by the company. -If something looked like it needed cleaning, "we will wipe it down."	D 282		

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D 282	Continued From page 83 -He thought the ice machine company had been out "about 1 ½ months ago because it was broken." -He had never washed any dish storage trays other than sending them through the dishwasher with dirty dishes. -He had never been instructed to do any special cleaning on the dish storage trays. -He thought they looked dirty because they were "just old." -The cook was responsible for cleaning the cook area and stove. -If the dietary manager wanted them to do a deep clean, they would work more hours, and they would be on the schedule to do extra cleaning 2 times per week. -The last deep cleaning they had done was prior to the dietary manager leaving in August 2017. -They do extra cleaning if they have time to do it. Interview with a third dietary aide on 12/19/17 at 9:28 a.m. revealed that maintenance was responsible for cleaning the doors going into the kitchen. Interview with a cook on 12/13/17 at 4:09 p.m. revealed: -They did not have a cleaning schedule. -The dietary aides were supposed to clean the mobile food transport cart between every meal. Interview with the same cook on 12/19/17 at 9:29 a.m. revealed: -Housekeeping should clean the doors and windows in the dining room. -The kitchen staff would wipe down "every now and then." -If she saw something on the walls in the kitchen, she would wipe it off. -Anyone in the kitchen could clean when they	D 282		

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D 282	Continued From page 84 didn't have anything else to do. -If she saw the dietary aides not doing anything, she would tell the dietary aides to get a rag and start wiping. -Whoever put stock up was responsible for the stock room, including sweeping, mopping, cleaning and throwing out the boxes. -The stock person usually left things clean and neat. -She did not know there were totes that were dirty in the stock room. -She thought the glove in the tote probably just fell into the container by accident. -The totes should not have food particles in the bottom. -The totes just needed to be cleaned. -She was not aware that there were shelves in the cooler that needed cleaning. -Anyone who saw it should have wiped them off. -The fan area should be cleaned by the maintenance staff. -She was not aware that there was a buildup of dust on the fan cover. -They could wipe the cover off but not the fan. -They did not have a cleaning schedule and had not had one since the dietary manager left. -The stove and oven were old and could not be cleaned. Interview with the Administrator on 12/19/17 at 9:59 a.m. revealed: -The entire kitchen staff was responsible for cleaning the kitchen. -He expected them to clean after each meal and after each shift to make sure it was clean for the next shift. -The walls and doors should be cleaned as needed by the kitchen staff. -The floors should be cleaned at the end of each shift.	D 282		

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D 282	Continued From page 85 -He made rounds in the kitchen "about every day." -He had noticed the kitchen needed to be cleaned and had a meeting with the kitchen staff the 1st week of November 2017. -He had noticed some improvement. -He was interviewing for a dietary manager. Observation of the doors going into and out of the kitchen area on 12/19/17 at 10:05 a.m. revealed no cleaning had been done. Interview with the Maintenance Technician on 12/20/17 at 12:10 p.m. revealed: -He was responsible for any needs related to plumbing and minor maintenance issues like adjusting temperatures in the kitchen. -If there were any major issues in the kitchen, he called his supervisor, and they would send someone else out to do those repairs. -He was not aware there was a loose gasket on the walk-in cooler. -He had not received a work order on the gasket. -He would look at it and if he couldn't take care of it, they would have someone sent in to repair it. -If he walked through the kitchen and saw something that needed to be done, he would do it. -He did not routinely go in the walk-in cooler or freezer unless there had been a work order. -He had gone into the walk-in cooler about 1 month back due to a temperature adjustment and had not noticed the gasket. Interview with a second cook on 12/20/17 at 12:42 p.m. revealed: -The stove/oven could not be properly cleaned because the pilot light was on 24 hours a day. -You could not use any cleaning chemicals on it. -The only way to clean the stove was to sand	D 282		

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D 282	Continued From page 86 blast it. -After each meal the dietary staff would mop the floors, clean the dining hall and all work areas. -He had not noticed the dining room doors needed to be cleaned. -The doors had been cleaned last week (12/11/17). -The tea machine was cleaned daily. -The walls could not be cleaned because they were just old and stained. -The coffee machine was run through the dishwasher. -The beverage machine was wiped off daily. -Cleaning the ice-machine was done by the leaser. -The stock room was swept and mopped daily. -They made sure things were off the floor daily. -All the shelves needed to be wiped off "just about daily." -Had noticed the discoloration of the dish storage trays and thought the discoloration was from age. -The dish storage trays went through the dish washer every day. -The coolers and the ice machine were wiped off once a week. Observation of the doors going into and out of the kitchen area on 12/20/17 at 10:59 a.m. revealed no cleaning had been done.	D 282		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.	D 283		

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D 283	Continued From page 87 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure food that was unwrapped was passed out to residents following sanitation and safety guidelines in the Special Care Unit (SCU) in the men's hall dining room. The findings are: Observation during the lunch meal on the men's hall in the SCU on 12/14/17 at 12:30 p.m. revealed: -There were fifteen residents in dining room. -The meal included a cookie. -A Personal Care Aide (PCA) had passed out a cookie to a resident using her bare hands without wearing gloves, a napkin or using a serving utensil. -She was not observed washing her hands. -The surveyor stopped the PCA, before she passed out cookies to other residents. Interview with the same PCA on 12/14/17 at 12:30 p.m. revealed: -She usually passed out cookies to residents using her bare hands without wearing gloves on her hands, using a napkin or serving utensils. -Sometimes she used a napkin to pass out snacks or food that was not wrapped or if there was no serving utensil. -She forgot to put on gloves before she started serving cookies to the residents. -She had training in sanitation and safety, but she could not remember when she had the training. Interview with a second PCA on 12/14/17 at 12:52 p.m. revealed if staff passed out food, such as cookies, to residents and it was not wrapped, she wore gloves to pass it out to the residents.	D 283	All staff will be in-service by 2/4/18 to ensure that sanitation and safety guidelines are followed during all meal times. Med Aides, CNA's, and PCA's will ensure hands are washed and cleaned before assisting resident with meals. Gloves will be worn as appropriate and serving utensils utilized by all staff within facility. ED, CM, and BOM will monitor on weekly basis.	

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D 283	Continued From page 88 Interview with a Medication Aide/PCA on 12/14/17 at 1:02 p.m. revealed: -If a resident's meal included a cookie for lunch staff washed their hands, put on gloves or just passed out the cookie to the resident using their bare hands. -She had been doing that within the past month. -No one told her to pass out cookies using her bare hands. -"You follow what you see." -She just observed other staff passing out cookies without wearing gloves, using a napkin or using serving utensils. -During the lunch meal on 12/14/17, she washed her hands and passed out cookies to residents. She did not wear gloves, use a serving utensil or a napkin. Observations of the dinner meal on the men's hall in the SCU on 12/14/17 at 5:30 p.m. revealed: -Sixteen residents were in the dining room on the men's hall. -Staff served the meal to the residents following sanitation and safety guidelines. Confidential interview with a staff revealed: -The staff monitored a meal daily. -Staff were supposed to wear gloves when passing out food, such as cookies, to residents if they did not use napkins or serving utensils. -Staff were not supposed to pass out food using their bare hands. -The staff was not aware staff was passing out food with their bare hands. -If they were aware, staff would have been re-educated and corrected. Interview with a cook on 12/19/17 at 9:29 a.m. revealed: -Staff should never touch open food with their	D 283		

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D 283	Continued From page 89 bare hands, they should use gloves or take a napkin and pick it up. -The dietary aides always used gloves or tongs. -They sent tongs with packs of food for staff to use when serving opened food. Interview with a second cook on 12/20/17 at 1:24 p.m. revealed that he expected all staff to use gloves to touch any opened foods. Interview with the Administrator on 12/19/17 at 9:59 a.m. revealed he expected staff to always wash their hands and wear gloves when passing out open food.	D 283		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure 8 ounces (oz) of milk was served to the residents on the men's hall in the Special Care Unit (SCU) twice daily. The findings are:	D 299	All dietary staff will ensure milk is served on SCU two times a day. ED, CM, and BOM will ensure milk is served in 8 ounce cups on daily basis. Staff was in-serviced on 12/14/17. BOM or designee will monitor inventory to ensure adequate kitchen supply. Plan of correction date is 2/4/18.	

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D 299	Continued From page 90 Review of the "Thursday December 14, 2017" dinner menu included 1 cup (cp) of milk to be served to the residents. Observations of the dinner meal on the men's hall in the SCU on 12/14/17 at 5:30 p.m. revealed: -Sixteen residents were in the dining room on the men's hall. -The residents received 6 oz of water and another beverage. -None of the residents was served milk. Interview with as Medication Aide on 12/14/17 at 1:02 p.m. revealed: -Dietary sent small cups and regular cups during the meals to be served to the residents. -She did not know the size of the cups. Interview with a Personal Care Aide (PCA) on 12/14/17 at 5:50 p.m. revealed: -Milk was offered to residents at breakfast and at lunch. -If the residents wanted the milk, staff gave the residents milk. -If the resident did not want the milk, staff did not give the resident milk. -Milk was offered to the residents during the dinner meal on 12/14/17, but none of the residents wanted the milk. Review of "Friday December 15, 2017" lunch meal menu did not include milk to be served to the residents. Observation of the lunch meal on the men's hall in the SCU on 12/15/17 at 12:30 p.m. revealed: -Fourteen residents were in the dining room. -A PCA passed out milk to certain residents. -Ten of fourteen residents were served 6 oz milk. -Eight of fourteen residents was served 1 cup	D 299		

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D 299	Continued From page 91 (cp) of coffee. -All fourteen residents received one cp of water and another beverage. Interview with a second PCA on 12/15/17 at 12:48 p.m. revealed: -The residents in the SCU were offered milk three times daily. -The milk was offered to the residents who had coffee only. -If the residents asked for milk, staff gave it to them. -She was told to do that by another staff member, since August 2017. Confidential interview with a staff member revealed: -The staff member monitored a meals daily. -Staff passed out 4 oz milk to the residents during the meals. -Residents received 4 oz milk with meals, since the staff member had been working at the facility. -The staff member was not sure if the residents requested a refill on the milk. Interview with a cook on 12/19/17 at 9:29 a.m. revealed: -Water, milk and juice are required to be served at breakfast. -They also offered coffee and tea in the mornings. -Milk was supposed to be offered at every meal "but some don't want it." -In the SCU they should provide milk at every meal. Interview with a second cook on 12/20/17 at 1:24 p.m. revealed: -At breakfast, the residents were provided milk, water and a juice.	D 299		

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D 299	Continued From page 92 -Milk was provided in 8 oz cups. -At lunch and dinner, the residents were provided tea, water and milk. -Some residents requested sodas and they would get those too. -In the SCU, the residents were given pre-poured 8 oz glasses of milk with each meal. -At one time, they did not have enough 8 oz cups and had used smaller cups. -It had been a while since they had to do that. -He had been using 8 oz cups for milk for "some time." -He had been off for a week and today (12/20/17) was his first day back and was not aware the staff had been using 4 oz cups for milk. Interview with the Administrator on 12/19/17 at 9:59 a.m. revealed: -Milk should be offered at all 3 meals. -It had been brought to his attention that they were using the 4 oz cp instead of an 8 oz cp. -The staff had been made aware that they were supposed to be using 8 oz cups from now on.	D 299		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record	D 338	CM and/or SIC will continue to follow community process when a behavior occurs. Process includes communicating with management regarding inappropriate behaviors, notifying Physician and Responsible Party (RP), increase supervision. When behavior is identified that requires EMS involvement, both residents will be separated	

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D 338	Continued From page 93 reviews, the facility failed to assure 8 residents (#1, #6, #10, #14, #15, #16, #17 and #18) who resided on the Special Care Unit (SCU) were protected from assualt by Resident #9 who was known to have aggressive behaviors; and residents on the SCU were protected from assualt by Resident #1 who was also known to have aggressive behaviors. The findings are: 1. Review of Resident #9's current FL-2 dated 3/29/17 revealed diagnoses included Alzheimer's Dementia, Essential Hypertension, Bilateral Cataracts, Gastro-esophageal Reflux Disease and Arthritis. Review of Resident #9's current care plan dated 3/10/17 revealed: -Resident #9 wandered, had verbally and physically abusive behaviors and was resistant to care. -Resident #9 was receiving services and medications for behaviors/mental illness. Confidential interview with a staff revealed: -Resident #9 had a pattern of hitting residents. -Resident #9 was sent to the hospital after hitting two residents and had some medication changes before the incident with Resident #10 (November 2017). A week after returning from the hospital, Resident #9 slapped another resident. -Resident #9 had pushed Resident #10 down to the floor in the day room and caused Resident #10 to have a broken hip about a month ago (November 2017). Based on observations, interviews and record reviews, Resident #9 was not available for interview due to hospitalization since 12/4/17.	D 338	CM/SIC will provide additional supervision of the threatening resident to protect other residents from harm. Care plan meeting will be scheduled as needed to address any resident behavior. Psych service referral will be obtained by PCP if not already being followed. In-service was completed 12/22/17 by RN which included Managing Aggressive Behavior, Hot Box, Mood/Behavior Log, The Bucket System, and Communication Log. Plan of correction date is 1/20/18.	

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D 338	Continued From page 94 Telephone interview with Resident #9's Guardian on 12/20/17 at 5:23pm revealed: -Resident #9 did not hear so well and misunderstood what people were saying to her. -It was hard for Resident #9 to not be in her own home. -When Resident #9 was at home, she would spend her time moving clothes from one room to another. -Resident #9 seemed to have gotten worse with her behaviors over the last three or four months because staff had been calling the Guardian more often. -When Resident #9 first got to the facility, she was in a room by herself. -Resident #9 got into an altercation with another resident the first day they moved her with another resident. -Resident #9 got more confused because she was moved from one room to another. Telephone interview with a Medication Aide (MA) on 12/20/17 at 4:09am revealed: -Resident #9 was usually awake all night. -Most of the problems for Resident #9 came from her having a roommate. -Resident #10, Resident #14 and a third resident had been Resident #9's roommates and had been hit by Resident #9. -Staff would redirect Resident #9 and distract her with snacks. Interview with a Personal Care Aide (PCA) on 12/19/17 at 2:35pm revealed: -A resident was moved to Resident #9's old room on 12/4/17, and Resident #9 saw the resident come out of the room with a sweater. -Resident #9 tried to take the sweater from the other resident.	D 338		

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D 338	Continued From page 95 -She tried to break up the confrontation between Resident #9 and the other resident, but Resident #9 reached from behind the PCA and slapped the other resident. -She reported aggressive behaviors to the MA/Manager on duty, the MA/Manager reported to the PCP. -The PCP changed the resident's medications and "that was it." Telephone interview with a second PCA on 12/20/17 at 4:35pm revealed: -Resident #9 "was always having altercations with other residents ...she was real possessive over her stuff and her space, she could not stand to have a roommate." -Resident #9 was very sweet when she was first admitted to the facility (12/16/15) and did not "start acting like this" until she got a roommate. -She was not sure, but thought Resident #9's 1st roommate was around the beginning of 2017. Interview with a second MA on 12/19/17 at 11:33am revealed: -Resident #9 would fight anyone, for any reason and had been that way since her admission to the facility (12/16/15). -Staff would "never see it coming," because Resident #9 would "just hall off and hit somebody walking by." -Resident #9 was "particularly violent" when another resident went into her room. -Resident #9 wandered into other resident rooms and took their clothes. -Staff would have a difficult time getting other resident's clothes back from Resident #9. -Staff tried to keep Resident #9 calm by seeing what she liked to do and involve her in activities or give her snacks. -The activities and snacks "did not do any good"	D 338		

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D 338	Continued From page 96 for Resident #9. -Resident #9 was IVCd on 12/4/17 because staff could not get the resident to stop fighting. -The younger staff were afraid of Resident #9. Interview with a third MA on 12/19/17 at 2:20pm revealed: -Resident #9 was "very combative with residents" and her behavior was unpredictable. -Resident #9 was especially aggressive about her room or what she thought was her room. -Resident #9 had wandered into other resident rooms and thinking that it was her room, she would "jump on residents" who went into their own room. Telephone interviews with Resident #9's PCP on 12/19/17 at 3:25pm and 12/20/17 at 2:22pm revealed: -Resident #9 was territorial and highly provoked whenever another resident wandered into her space. -He was not aware of the details of the altercation on 12/4/17, but staff did notify him. -The incidents involving Resident #9 would probably have been more frequent if staff had not been trying, but the incidents were hard to prevent with the limited number of staff compared to the number of residents. -Resident #9 needed a short term behavioral health controlled environment and once stabilized would be okay for the Special Care Unit (SCU). Interview with the MCM on 12/20/17 at 2:49pm and 12/21/17 at 2:13pm revealed: -Resident #9's behavior had been more harmful to residents over the last one and a half to two months. -Resident #9 had a concern for other residents getting into her personal space.	D 338		

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D 338	Continued From page 97 -There were altercations between Resident #9 and other residents because residents were free to wander and Resident #9 was free to come out in the common areas. -She had communicated Resident #9's aggressive behavior to the PCP. -Staff implemented recommendations from the PCP to keep residents out of Resident #9's space. Interview with the Administrator on 12/21/17 at 2:13pm revealed: -Resident #9 had had aggressive behaviors for approximately one year which had been occurring more frequently, but not with more severity except the incident resulting in a resident having a fractured pelvis. -In addition to communicating with the PCP, staff also communicated with the family and there were medication changes. Review of a PCP visit note dated 9/21/17 for Resident #9 revealed: -Staff reported Resident #9 remained territorial and agitated when other residents wandered into her space. -As long as staff could keep other residents out of Resident #9's room, she was fine. -Resident #9 reported on exam she was going to get a big stick and hit them; she did not like when other residents came into her room. -Staff had been "educated multiple times" to redirect wanderers from Resident #9's room; and there had been no recent altercations in over a month so it seemed to be working. Review of electronic Charting Notes and Accident/Injury reports dated 6/1/17 through 12/18/17 revealed there were a total of 13 incidents where Resident #9 had hit, pushed or	D 338		

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D 338	Continued From page 98 had an "altercation" with at least eight different residents. A. Review of Resident #10's current FL-2 dated 3/29/17 revealed: -Diagnoses included Alzheimer's dementia, left artificial hip joint, feeding difficulty and essential primary hypertension. -Resident #10 was ambulatory. -Resident #10 was constantly disoriented. Review of Resident #10's care plan dated 06/09/17 revealed: -Resident #10 had significant memory loss. -Resident #10 was ambulatory and wandered. -Resident #10 required assistance with bathing and dressing. -Resident #10 was able to feed herself but required supervision and redirecting due to her dementia. Review of an Accident/Injury Report for Resident #10 dated 11/27/17 revealed: -The staff completing the form was a MA. -The date and time of the incident was 11/27/17 at 2:47 p.m. -The Administrator signed the report on 11/28/17. -The MA documented that Resident #10 was observed in a sitting position on the floor. -The MA documented in additional notes that Resident #10 complained of pain and the Primary Care Provider (PCP) ordered an x-ray of the right hip and the x-ray showed Resident #10 had a hip fracture and therefore was transported by EMS to local hospital. Review of Resident #10's x-ray results revealed the mobile x-ray imaging dated 11/27/17 documented a mildly impacted fracture of the right femoral neck was suspected and further	D 338		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 99 evaluation was recommended for confirmation. Review of a hospital discharge record for Resident #10 dated 11/27/17 revealed: -Resident #10 had a contusion of the right hip. -There was a hand-written note on the discharge papers by the PCP that a 2nd opinion at a different local hospital revealed a fracture. Telephone interview with Resident #10's Power of Attorney (POA) on 12/18/17 at 2:09 p.m. revealed: -She found out later about the 10/03/17 incident and was told by staff that they left her a message. -She was notified of the incident on 11/27/17, that Resident #10 was sent to a local hospital, and returned to the facility. -She was surprised to get a call from a surgeon at the local hospital to give permission for Resident #10 to have surgery. -She was upset about Resident #10 being at the hospital by herself and had she known she would have been there with her. -Resident #10 broke her hip after being pushed by another resident. -Resident #10 was at a local rehabilitation center secondary to having a hip replacement. Interview with the Memory Care Manager (MCM) on 12/19/17 at 2:30 p.m. revealed: -Resident #9 had an altercation on 11/27/17 with Resident #10, resulting in an injury. -She was in her office when the altercation occurred on 11/27/17. -She was told Resident #10 had gotten too close to Resident #9 and was pushed by Resident #9. -Resident #10 was pushed so hard she slid across the floor of the day room. -They did not call 911 at the time because Resident #10 did not appear to be injured.	D 338		

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D 338	Continued From page 100 -Resident #10 was later observed having difficulty walking. -They called the PCP who directed them to have an x-ray company come to the facility to do an x-ray. -The mobile x-ray company noted a possible fracture and recommended further evaluation. -Resident #10 was sent to a local hospital and returned to the facility with a diagnosis of a contusion. -The PCP wanted a second opinion and Resident #10 was sent to another local hospital who determined it was fractured and scheduled Resident #10 for surgery. Telephone interview with Resident #10's PCP on 12/19/17 at 3:25 p.m. revealed: -Resident #10 had a history of falls. -A lot of Resident #10's falls were related to altercations with other residents. -He knew Resident #10 had been pushed down. -Resident #10 had been an aggressor in the past; however he had been able to find a happy "medium" to keep her safe with changes in her medication. -He felt Resident #10 had become a target of others. Interview with a MA on 12/19/17 at 10:25 a.m. revealed: -She was working with another resident when Resident #10 was pushed by Resident #9. -She did not know why the incident happened. -She did not recall Resident #10 and Resident #9 having any other altercations. -She had never been given any information to keep Resident #10 separated from Resident #9. Interview with a PCA on 12/19/17 at 10:33 a.m. revealed:	D 338		

Division of Health Service Regulation

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D 338	Continued From page 101 -She had heard the commotion on 11/27/17 when Resident #10 had fallen. -When she came into the hall, Resident #10 had been moved into the nursing office. -Another staff told her Resident #9 had pushed Resident #10 so hard that she fell. -She had not seen Resident #10 "mess" with anyone. -She was not aware of any other incidents with Resident #10. Telephone interview with a second MA on 12/20/17 at 4:09 a.m. revealed Resident #10 had been Resident #9's roommate and had been hit by Resident #9. Interview with a third MA on 12/20/17 at 5:49 p.m. revealed: -He instructed staff when he was working to keep Resident #10 away from Resident #9. -He tried to prevent incidents by keeping residents known to be aggressive away from situations that might escalate and redirecting residents. -There were residents who could be hostile. -"You must know your residents and pass information onto other staff." -"Preventive intervention goes a long way." -If he knew 2 residents didn't get along and he saw them together, he would separate them and redirect. Interview with the Administrator on 12/21/17 at 2:05 p.m. revealed: -The incident on 11/27/17 involved Resident #9 and Resident #10. -He was aware of Resident #9's behaviors. -Resident #9 had behavior problems for approximately 1 year. -The incidents had become more frequent in the	D 338		

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D 338	Continued From page 102 last 1 1/2 to 2 months. -Resident #9 had been involuntarily committed (IVCd) due to her behaviors. -When a resident assaulted someone, they would reach out to the PCP, family and follow PCP recommendation. Interview with the MCM on 12/21/17 at 2:14 p.m. revealed: -Resident #9's actions had been more severe recently, where she actually harmed other residents. -Only 1 incident had resulted in an injury and that was with Resident #10. -They had implemented the PCP's recommendations for Resident #9, such as keeping people out of her space. Based on observations, interviews and record reviews, Resident #10 was not available for interview. B. Review of Resident #14's current FL-2 dated 3/29/17 revealed diagnoses included Alzheimer's Dementia, Hypercholesterolemia, Chronic Obstructive Pulmonary Disease and Depression. Telephone interview with a Medication Aide (MA) on 12/20/17 at 4:09am revealed Resident #14 had been Resident #9's roommate and been hit by Resident #9. Review of Charting Notes for Resident #14 dated 10/18/17 at 4:50am revealed staff documented another resident (#9) hit Resident #14 for being in her room. Upon request on 12/14/17 through 12/21/17, there were no incident reports available for review for Resident #14.	D 338		

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D 338	Continued From page 103 Review of an electronic Charting Note dated 10/18/17 at 4:47am for Resident #9 revealed staff documented Resident #9 hit another resident around 2:00am "because she (Resident #9) was mad because the resident was in her (#9) room." Review of an Accident/Injury Report dated 10/18/17 at 2:00am for Resident #9 revealed staff documented Resident #9 was hitting another resident. There were no injuries. Interview with the Administrator on 12/21/17 at 2:05pm revealed Resident #9 hit Resident #14 on 10/18/17. Review of a PCP visit note dated 10/19/17 for Resident #9 revealed: -Resident #9 attacked another resident after that resident was transferred into Resident #9's room. -Staff were expected to redirect the resident and avoid placing residents in Resident #9's room. Review of an electronic Charting Note dated 10/30/17 at 12:12pm for Resident #9 revealed staff documented Resident #9 "was involved in an altercation with another resident, hitting her (the other resident) in the face with a shoe three times." Review of an Accident/Injury Report dated 10/30/17 at 11:34am for Resident #9 revealed staff documented Resident #9 hit another resident in the face three times, there were no injuries. Review of a PCP visit note dated 11/2/17 for Resident #9 revealed: -Resident #9 had been involved in another altercation due to intrusion from the other resident	D 338		

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D 338	Continued From page 104 into her space. -Staff were expected to keep other residents out of Resident #9's room to avoid altercations. Interview with the Administrator on 12/21/17 at 2:05pm revealed Resident #9 hit Resident #14 on 10/30/17. C. Review of Resident #16's current FL-2 dated 6/20/17 revealed diagnoses included Dementia with Behavioral Disturbance, Bradycardia, Euthyroid Goiter, Hyperlipidemia and Essential Hypertension. Review of Charting Notes for Resident #16 dated 7/22/17 revealed on 7/22/17 at 6:27pm, staff documented the resident was struck twice in the face by another resident. Review of an Accident/Incident Report for Resident #16 revealed: -There was a report dated 11/11/17 at 6:55am that documented Resident #16 was hit in the face by another resident. -There was a note to "see additional notes," but there were no additional notes available for review. -There was no documentation of any injuries. -The report noted that Resident #16 was sent out to the emergency room (ER). Review of Charting Notes for Resident #16 dated 11/11/17 revealed: -On 11/11/17 at 1:59pm, staff documented Resident #16 returned from the ER with no new orders or medications. -There was no note documenting why Resident #16 was sent to the ER following the incident at 6:55am on 11/11/17.	D 338		

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D 338	Continued From page 105 Review of an electronic Charting Note dated 11/11/17 at 9:17am revealed staff documented Resident #9 hit two residents in the face, the on call provider was notified and instructed staff to send Resident #9 to the ER for evaluation. Telephone interview with a Personal Care Aide (PCA) on 12/20/17 at 4:35pm revealed: -She was working the morning of 11/11/17 when Resident #9 hit Resident #16 and a second resident in the face. -She did not see the incident. -Another PCA reported that Resident #9 hit a resident (#16) who was just walking by. D. Review of Resident #6's current FL-2 dated 3/29/17 revealed: -Diagnoses included vascular dementia without behavior disturbances, hypertension, hypothyroidism, generalized anxiety disorder and abnormal weight loss. -Resident #6 was constantly disoriented. Review of an electronic Charting Note dated 6/6/17 at 3:15pm for Resident #9 revealed staff documented Resident #9 hit a resident in the face. Review of an Accident/Injury Report dated 6/6/17 at 2:33pm for Resident #9 revealed staff documented Resident #9 was involved in an altercation with another resident with no injuries. Interview with the Administrator on 12/21/17 at 2:05pm revealed Resident #6 was the resident hit by Resident #9 on 6/6/17. Attempted interview on 12/18/17 at 12:39pm with staff who discovered the incident on 6/6/17 involving Resident #9 and Resident #6 was	D 338		

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D 338	Continued From page 106 unsuccessful. Review of an electronic Charting Note dated 9/15/17 at 8:02pm for Resident #9 revealed staff documented Resident #9 was involved in an altercation with another resident. Review of an Accident/Injury Report dated 9/15/17 at 1:15pm for Resident #9 revealed staff did not document any details or description of an incident, but documented there were no injuries and the PCP's office was notified. Interview with the Administrator on 12/21/17 at 2:05pm revealed Resident #6 was involved in the altercation with Resident #9 on 9/15/17. E. Review of Resident #1's current FL2 dated 11/21/17 revealed: -Diagnoses included of Alzheimer's dementia with behavioral disturbance, history of depression, syncope, coronary artery disease, controlled type II diabetes, hypertension, chronic kidney disease, and hyperlipidemia. -Resident #1 was disoriented, wandered and was nonverbal. Review of an electronic Charting Note dated 11/10/17 at 7:01pm for Resident #9 revealed staff documented Resident #9 was standing over another resident that was laying in her room on the floor. Review of an Accident/Injury Report dated 11/10/17 at 5:45am for Resident #9 revealed staff documented Resident #9 was standing over top of another resident that was in her room and there were no injuries. Interview with the Administrator on 12/21/17 at	D 338		

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D 338	Continued From page 107 2:05pm revealed Resident #1 was the resident on the floor in Resident #9's room on 11/10/17. Review of an electronic Charting Note dated 11/10/17 at 7:01pm for Resident #1 revealed on 11/10/17 at 6:59pm (late entry) staff documented Resident #1 was found on the floor in another resident's room with that resident (9) standing over her. Attempted interviews on 12/14/17 at 6:25pm and 12/15/17 at 1:56pm with the staff who discovered the incident on 11/10/17 involving Resident #9 and Resident #1 were unsuccessful. F. Review of an electronic Charting Note dated 7/11/17 at 10:30pm for Resident #9 revealed staff documented Resident #9 hit a resident that walked into her room. Review of an Accident/Injury Report dated 7/11/17 at 1:55pm for Resident #9 revealed staff documented Resident #9 was standing in her room by the door. Interview with the Administrator on 12/21/17 at 2:05pm revealed Resident #17 was the resident hit by Resident #9 on 7/11/17. Attempted interview with staff who completed the Accident/Incident Report dated 7/11/17 for Resident #9 on 12/18/17 at 12:40pm was unsuccessful. Review of a Primary Care Provider (PCP) visit note dated 7/13/17 for Resident #9 revealed Resident #9 struck another resident in the face after the resident entered Resident #9's room, resulting in superficial injuries to the other resident.	D 338		

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D 338	Continued From page 108 Review of an electronic Charting Note dated 8/15/17 at 6:40pm for Resident #9 revealed staff documented Resident #9 was observed hitting another resident. Review of an Accident/Injury Report dated 8/15/17 at 3:40pm for Resident #9 revealed staff documented Resident #9 was observed hitting another resident with no injury. Interview with the Administrator on 12/21/17 at 2:05pm revealed Resident #17 was the resident hit by Resident #9 on 8/15/17. Review of a PCP visit note dated 8/17/17 for Resident #9 revealed: -Resident #9 was involved in an altercation with another resident from what appeared to be an intrusion into Resident #9's personal space. -This was "the 3rd occurrence in five weeks under the exact same circumstances." G. Review of an Accident/Injury Report dated 11/4/17 at 6:05pm for Resident #9 revealed staff documented Resident #9 hit another resident in the face and there were no injuries. Review of electronic Charting Notes for Resident #9 revealed there was no entry for the 11/4/17 incident. Interview with the Administrator on 12/21/17 at 2:05pm revealed Resident #9 hit Resident #15 on 11/4/17. Review of an electronic Charting Note dated 11/11/17 at 9:17am for Resident #9 revealed staff documented Resident #9 hit two residents in the	D 338		

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D 338	Continued From page 109 face, the on call provider was notified and instructed staff to send Resident #9 to the emergency room (ER) for evaluation. Review of an Accident/Injury Report dated 11/11/17 at 6:30am for Resident #9 revealed staff documented Resident #9 was observed hitting another resident, the on call provider at the PCP's office was notified and Resident #9 was sent to the ER. Review of an Accident/Injury Report dated 11/11/17 at 6:30am for Resident #15 revealed staff documented Resident #15 "was involved in an altercation with another resident," there were no injuries, Resident #15 was sent to the ER and returned to the facility with no new orders. Telephone interview with a Personal Care Aide (PCA) on 12/20/17 at 4:35pm revealed: -She was working the morning of 11/11/17 when Resident #9 hit two residents in the face. -She did not see the incident. -Another PCA reported that Resident #9 had hit a resident who was just walking by. H. Review of an electronic Charting Note dated 12/4/17 at 10:43pm revealed staff documented Resident #9 was Involuntarily Committed (IVCd) "because of an altercation with another resident." Interview with a Personal Care Aide (PCA) on 12/19/17 at 2:35pm revealed: -Resident #18 was moved to Resident #9's old room on 12/4/17, and Resident #9 saw Resident #18 come out of the room with a sweater. -Resident #9 tried to take the sweater from the Resident #18. -She tried to break up the confrontation between Resident #9 and the Resident #18, but Resident	D 338		

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D 338	Continued From page 110 #9 reached from behind the PCA and slapped the Resident #18. -She reported the incident to the Medication Aide (MA) on duty and had seen the MA fill out an incident report. Interview with a MA on 12/20/17 at 5:49pm revealed: -On 12/4/17, Resident #9 took Resident #18's jacket; Resident #18 went to take the jacket back and Resident #9 slapped the other resident. -He had notified the MCM, completed an incident report for the 12/4/17 incident for both residents, put the incident report under the Administrator's door and reported the incident to the next shift MA. Review of Charting Notes and Accident/Incident Reports for Resident #9 revealed there was no documentation of incidents involving Resident #9 and Resident #18on 12/4/17. _____ The facility's failure to protect residents on the Special Care Unit from another resident (#9) who was well known by staff and documented by the physician to become increasingly agitated when others wandered into her space, resulted in eight residents being hit or pushed, includeing on resident sustaining a pelvic fracture. The facility's failure constitutes a Type A1 Violation for serious neglect. _____ Review of the Plan of Protection submitted by the facility on 12/18/17 revealed: -Care Manager (CM) and/or Supervisor-In-Charge (SIC) will continue to follow community process. -When a behavior occurs, process includes communicating with management regarding	D 338		

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D 338	Continued From page 111 inappropriate behaviors, notifying physician and responsible parties, increase supervision. -CM or SIC will assign duties as appropriate based on residents' needs. -When behavior is identified, that require EMS involvement, both residents will be separated. -CM/SIC will provide additional supervision of the threatening resident to protect other residents from harm. -Care plan meeting will be scheduled as needed to address any resident behavior. -Psych service referral will be obtained by PCP if not already followed. -RN will educate staff on recognizing behaviors and understanding appropriate interactions to implement starting 12/14/17. -Mood/behavior monitoring and communication form was implemented to identify most effective interaction. -In-service with RN for all staff scheduled on 12/22/17 for managing the aggressive resident and interaction. -ED and CM will monitor mood/behavior form weekly through chart audits and observations. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 20, 2018.	D 338		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a	D 453	ED shall be responsible for ensuring incident reports are reported to Department of Social Services (DSS) in timely manner and as appropriate. MA's will write Incident Report	

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D 453	Continued From page 112 resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure the county Department of Social Services was notified of five incidents of physical and sexual assault of 4 of 15 sampled residents (#1, #2, #9 and #10). The findings are: 1. a. Review of Resident #9's current FL-2 dated 3/29/17 revealed diagnoses included Alzheimer's Dementia, Essential Hypertension, Bilateral Cataracts, Gastro-esophageal Reflux Disease and Arthritis. Review of electronic Charting Notes for Resident #9 revealed on 12/4/17 at 10:43pm, staff documented Resident #9 was Involuntarily Committed (IVCd) "because of an altercation with another resident." Review of Accident/Injury Reports revealed there was no incident report dated 12/4/17. Interview with a Personal Care Aide (PCA) on 12/19/17 at 2:35pm revealed: -A resident was moved to Resident #9's old room on 12/4/17, and Resident #9 saw the resident come out of the room with a sweater. -Resident #9 tried to take the sweater from the other resident. -She tried to break up the confrontation between Resident #9 and the other resident, but Resident #9 reached from behind the PCA and slapped the other resident. -She had to accompany Resident #9 to the hospital, where during the transport, Resident #9 hit the PCA in the nose and spit on the Sheriff. -She reported the incident to the Medication Aide	D 453	and CM will review. DSS will be contacted via fax when residents are IVC'd and when a 24hr/5day report is submitted. ED and CM will work collaboratively on all Incident Reports. ED and CM will discuss and educate all staff on responsibility of reporting Incident Reports by 2/4/18.	

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D 453	Continued From page 113 (MA) on duty and had seen the MA fill out an incident report. Interview with a second MA on 12/20/17 at 5:49pm revealed: -On 12/4/17, Resident #9 took another resident's jacket. -The resident went to take the jacket back and Resident #9 slapped the other resident. -When an incident happened, staff were expected to notify the Memory Care Manager (MCM) and the MCM would notify the Primary Care Provider (PCP). -He had notified the MCM, completed an incident report for the 12/4/17 incident for both residents, put the incident report under the Administrator's door and reported the incident to the next shift MA. Upon request 12/14/17 through 12/21/17, an Accident/Incident report for the resident involved in the altercation on 12/4/17 with Resident #9 was not available for review. b. Interview with the Administrator on 12/15/17 at 11:07am revealed: -There had been an incident involving Resident #9 hitting a staff and then being hit by staff. -Resident #9 was trying to touch the staff's chest and then slapped the staff. -Staff responded by slapping Resident #9. -Resident #9 did not have any injuries and an incident report was not done. -He had completed the 24 hour and five day Health Care Personnel Registry reports for the incident. -He was made aware of the incident the 1st week in October 2017, but believed the incident occurred the last week of September 2017. -The staff was no longer employed at the facility.	D 453		

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D 453	Continued From page 114 Review of electronic Charting Notes dated 8/28/17 through 12/18/17 for Resident #9 revealed there was no documentation of an incident where a staff hit Resident #9 and what was done about the alleged incident. Upon request 12/14/17 through 12/21/17, an Accident/Incident report for the incident involving Resident #9 being hit by a staff was not available for review. Interview with the Department of Social Services (DSS) worker on 12/14/17 at 10:08am revealed he did not have an incident report on a staff hitting a resident within the last three months. Refer to telephone interview with the DSS Supervisor on 12/21/17 at 11:27am. Refer to confidential interview with a staff. Refer to telephone interview with a PCA on 12/20/17 at 4:35pm. Refer to telephone interview with a MA on 12/20/17 at 4:09am. Refer to interview with the MCM on 12/19/17 at 11:00am and 12/20/17 at 2:49pm. Refer to interview with the Administrator on 12/21/17 at 2:13 p.m. 2. Review of Resident #10's current FL-2 dated 3/29/17 revealed diagnoses included Alzheimer's dementia, left artificial hip joint, feeding difficulty and essential primary hypertension. Review of a hospital discharge record for	D 453		

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D 453	Continued From page 115 Resident #10 dated 10/03/17 revealed the resident had been seen at a local hospital for a fall with no findings. Review of an Accident/Injury Report for Resident #10 provided on 12/18/17 revealed: -The report was completed on 10/03/17 for an altercation that occurred on 10/03/17. -The staff member completing the form was a Medication Aide (MA). -The date and time of the incident was 10/03/17 at 3:43 p.m. -The Administrator signed the report on 10/04/17. -The MA documented Resident #10 was slapped and pushed to the floor by another unnamed resident at 3:34 p.m. -The MA documented that Resident #10's head and tail bone struck the floor hard. -Resident #10 was transported by Emergency Medical Services (EMS) to a local hospital. Interview with a Medication Aide (MA) on 12/20/17 at 5:50 p.m. revealed: -On 10/03/17, he was in the nursing office at the change of shift. -On 10/03/17 a resident had pushed Resident #10 down, Resident #10 was sent out for examination and an incident report was completed. -A lot goes on in the Special Care Unit, you write it up and pass it on to the MCM and then on to the Administrator. -The Memory Care Manager (MCM) would let the Primary Care Provider (PCP) know of any changes with residents. -Incidents that were written up were altercations and falls. Interview with the Department of Social Services (DSS) worker on 12/14/17 at 10:08am revealed	D 453		

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D 453	Continued From page 116 he did not have an incident report on Resident #10 dated 10/03/17. Based on observations, interviews and record reviews, Resident #10 was not available for interview. Refer to telephone interview with the DSS Supervisor on 12/21/17 at 11:27am. Refer to confidential interview with a staff. Refer to telephone interview with a PCA on 12/20/17 at 4:35pm. Refer to telephone interview with a MA on 12/20/17 at 4:09am. Refer to interview with the MCM on 12/19/17 at 11:00am and 12/20/17 at 2:49pm. Refer to interview with the Administrator on 12/21/17 at 2:13 p.m. 3. Review current FL2 for Resident #1 dated 11/21/17 revealed: -Diagnoses included Alzheimer's dementia with behavioral disturbance, history of depression, syncope, coronary artery disease, controlled type II diabetes, hypertension, chronic kidney disease, and hyperlipidemia. Review of the current care plan for Resident #1 dated 7/24/17 revealed: -Resident #1 had wandering and physically abusive behaviors and was resistant to care. -Resident #1 was not receiving services and medications for behaviors/mental illness. -Extensive staff assistance was required for toileting, bathing, dressing, and grooming. -Limited staff assistance was required for	D 453		

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D 453	Continued From page 117 ambulation and transfer. -Resident #1 had a significant loss of memory and required direction from staff. -The resident was always disoriented. Review of electronic charting notes for Resident #1 dated 10/28/17 through 11/10/17 revealed: -On 10/28/17 at 6:38 p.m., resident observed by staff member engaged in sexual behavior with another resident. Staff will continue to monitor. -On 11/10/17 at 6:59 p.m., late entry, resident was found on floor in another resident's room with that resident standing over her. Review of Accident/Injury Reports for Resident #1 revealed there were no incident reports completed for an incident that was noted on 10/28/17 at 6:38 p.m. and an incident that was noted on 11/10/17 at 6:59 p.m. Confidential Interview with a staff revealed: -The sexual incident between Resident #1 and another male resident occurred on 10/28/17 at 9:45 a.m. -An incident was not completed because no one had been injured. -Resident #1 was monitored more closely after the sexual encounter. -Staff monitored Resident #1 every 15-minutes. -Resident #1's guardian was notified on 10/28/17 around 6:00 p.m. -Resident #1's primary care physician (PCP) was notified on 10/28/17 at 5:57 p.m. -Sometimes Resident #1 was found on the floor by staff in those areas of the SCU that were not visible from the main hallway. -Staff notified the Medication Aides (MA) of all falls or behavior incidents on the SCU. -There was another incident involving Resident #1 on 11/10/17, but an incident report was not	D 453		

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D 453	Continued From page 118 completed. -The staff was not aware of the guardian and PCP of Resident #1 being notified of the incident on 11/10/17. -On 11/10/17, Resident #1 was found on the floor of another resident's room with that resident standing over her. -An incident report was not completed because there were no observed injuries. Interview with the Department of Social Services (DSS) worker on 12/14/17 at 10:06 a.m. revealed he did not have incident reports for Resident #1 regarding an incident that was noted on 10/28/17 at 6:38 p.m. and an incident noted on 11/10/17 at 6:59 p.m. Interview with a Personal Care Aide (PCA) on 12/13/17 at 4:30 p.m. revealed: -Resident #1 was monitored more closely to prevent falls because she stumbles at times. -The Resident #1 wandered up and down the halls of the SCU and went into residents rooms. -She checked on all of the SCU residents including Resident #1 every 2 hours. -She informed the MA on duty or the Memory Care Manager (MCM) when incidents occurred in the SCU. Interview with a MA on 12/18/17 at 5:20 p.m. revealed: -Resident #1 had to be monitored "all of the time" because of her behaviors of touching her peers and hitting. -Residents could walk the halls of the SCU because they were "wanderers." -Resident #1 was in a locked unit so she thought it was okay for the resident to roam the halls. -Resident #1 went into everyone's plates and would take their food and drink even after the	D 453		

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D 453	Continued From page 119 resident had eaten. -Staff would take her from the table because she would take food from her peers. -She was monitored closely because of being a fall risk. 0She was not aware of any falls for Resident #1 with injuries. -"Eyes were to be kept on her, but after the 10/28/17 incident, staff were asked to monitor her more closely at all times." -Incident reports were completed for residents who received an injury as a result of a fall or an incident. -An incident report was not completed for the incident that occurred on 10/28/17 because there was no observed injuries. Interview with the MCM on 12/19/17 at 11:00 a.m. revealed: -Incident reports were not completed for the incidents that were deemed "unreportable." -The two incidents involving Resident #1 on 10/28/17 and 11/10/17 were considered "non-reportable" because there were no injuries to the resident. -The MAs completed incident reports for all incidents that were considered reportable. -For those incidents that were non-reportable, a charting note was completed. -The MA's were supposed to contact the guardian or contact person for residents as incidents occurred. -Resident #1's PCP and guardian were both notified and left a message for the incident involving Resident #1 on 10/28/17. -She was not sure if they were made aware of the incident that occurred on 11/10/17. Refer to telephone interview with the DSS Supervisor on 12/21/17 at 11:27am.	D 453		

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D 453	Continued From page 120 Refer to confidential interview with a staff. Refer to telephone interview with a PCA on 12/20/17 at 4:35pm. Refer to telephone interview with a MA on 12/20/17 at 4:09am. Refer to interview with the MCM on 12/19/17 at 11:00am and 12/20/17 at 2:49pm. Refer to interview with the Administrator on 12/21/17 at 2:13 p.m. 4.Review of Resident #2's current FL-2 dated 3/29/17 revealed: -Diagnoses included Alzheimer's dementia and hypertension. -Resident #2 was intermittently disoriented. Review of the accident/injury report dated 10/28/17 for Resident #2 revealed -A "sexual behavior was noticed" in the male dining room. -The incident occurred on 10/28/17 at 9:45 a.m. Review of the electronic charting notes for Resident #2 dated 10/28/17 at 6:38 p.m. revealed Resident #2 was engaged in a sexual behavior with another resident. Interview with the Department of Social Services (DSS) worker on 12/14/17 at 10:08 a.m. revealed he did not have an incident report on a sexual encounter between Resident #2 and another resident on 10/28/17. Refer to telephone interview with the DSS Supervisor on 12/21/17 at 11:27am.	D 453		

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D 453	Continued From page 121 Refer to confidential interview with a staff. Refer to telephone interview with a PCA on 12/20/17 at 4:35pm. Refer to telephone interview with a MA on 12/20/17 at 4:09am. Refer to interview with the MCM on 12/19/17 at 11:00am and 12/20/17 at 2:49pm. Refer to interview with the Administrator on 12/21/17 at 2:13 p.m. Telephone interview with the DSS Supervisor on 12/21/17 at 11:27am revealed she had followed up with the DSS worker and verified DSS had not received any incident reports for Resident #9 regarding staff hitting the resident in September 2017 and on 12/4/17 for the resident being IVC'd. Confidential interview with a staff revealed: -The Administrator would fire staff if he did not like the incident reports the staff had written. -The Administrator would have staff rewrite incident reports and if they refused he fired them. Telephone interview with a PCA on 12/20/17 at 4:35pm revealed: -She was responsible for reporting any accidents, incidents and/or injuries to the Medication Aide (MA). -The MAs were responsible for completing incident reports. Telephone interview with a MA on 12/20/17 at 4:09am revealed: -In cases where a resident was combative, the MAs were responsible for completing an incident report.	D 453	Note: This is inaccurate information and it is not the process or expectation by Administrator regarding reporting of incidents.	

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D 453	Continued From page 122 -If a resident assaulted another resident, an incident report was completed for both residents. -The completed incident reports were given to the Administrator to review. Interview with the MCM on 12/19/17 at 11:00am and 12/20/17 at 2:49pm revealed: -The MAs completed incident reports for reportable incidents. -She did not know right off all reportable incidents, but for some things staff just wrote a chart note. -There were changes in the facility's process for reporting incidents made since 12/14/17. -Accident/Incident reports were supposed to be completed by the MA for any incident with injuries resulting in the resident being sent to the emergency room (ER). Interview with the Administrator on 12/21/17 at 2:13pm revealed: -Incidents witnessed by the PCA were reported to the MA and the MA was responsible for completing the incident report. -The completed incident reports were given to the MCM and the MCM then gave the incident report to the Administrator. -The Administrator was responsible for sending the incident reports to DSS depending on the level of the incident. -If a resident was sent to the ER, then the incident report was sent to DSS. -If the resident was not sent to the ER, facility staff followed the recommendations of the PCP. -Law enforcement was not contacted for resident to resident assault in the SCU because residents' primary diagnoses was dementia.	D 453		

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D 464	Continued From page 123	D 464	Education was provided to ED and CM on 12/20/17 regarding SCU resident profile and care plan. The facility shall review all resident profiles to ensure quarterly reviews are updated and current. CM, LHPS Nurse, and Physician will communicate and ensure care plans are current with resident needs. ED and CM will monitor to ensure accuracy on resident profiles as needed. SCU profile and care plan updated by 2/4/18.	
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to complete quarterly profiles for 7 of 10 residents sampled who resided in the Special Care Unit (SCU) of the facility (#1, #2, #6, #9, #10, #12, #13). The findings are: 1. Review of Resident #10's current FL-2 dated 3/29/17 revealed diagnoses included Alzheimer's dementia, left artificial hip joint, feeding difficulty and essential primary hypertension.	D 464		

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D 464	Continued From page 124 Review of Resident #10's Resident Register revealed the resident was admitted on 01/31/15. Review of Special Care Unit Quarterly Profile for Resident #10 revealed there was no quarterly review completed since 10/27/16. Interview with the Memory Care Manager on 12/19/17 at 2:30 p.m. revealed: -She was responsible for making sure the quarterly reviews were completed. -She had not had the quarterly review updated on Resident #10. 2. Review of current FL2 for Resident #1 dated 11/21/17 revealed: -Diagnoses included Alzheimer's dementia with behavioral disturbance, history of depression, syncope, coronary artery disease, controlled type II diabetes, hypertension, chronic kidney disease, and hyperlipidemia. Review of Resident Register for Resident #1 dated 7/21/17 revealed the resident was admitted to the Special Care Unit (SCU) of the facility on 7/21/17. Review of the current care plan for Resident #1 dated 7/24/17 revealed: -Resident #1 had wandering and physically abusive behaviors and was resistant to care. -Resident #1 was not receiving services and medications for behaviors/mental illness. -Extensive staff assistance was required for toileting, bathing, dressing, and grooming. -Limited staff assistance was required for ambulation and transfer. -Significant loss of memory; must be directed. -The resident was always disoriented.	D 464		

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D 464	Continued From page 125 Review of SCU Quarterly Profiles for Resident #1's record revealed no quarterly profiles were completed since admission to the facility. Review of Accident/Injury Reports dated 10/28/17 revealed there was no incident report completed for the incident that occurred on 10/28/17 at 6:38 p.m. Review of the electronic charting notes for Resident #1 dated 10/28/17 through 10/30/17 revealed: -On 10/28/17 at 6:38 p.m., resident observed by staff member engaged in sexual behavior with another resident. Staff will continue to monitor. -On 10/29/17 at 6:42 p.m., resident kept under "extra supervision" during entire shift. No new incidents. -On 10/30/17 at 10:23 p.m., resident kept "under supervision" during shift. No sexual behavior noticed. Interview with the Memory Care Manager MCM on 12/19/17 at 11:05 a.m. revealed: -She was responsible for completing the residents' quarterly profiles in the SCU. -She wasn't going to make any excuses, she knew she was supposed to complete quarterly profiles for all SCU residents. -She had fallen behind and would correct the residents' records. -She did not complete any quarterly profiles for Resident #1. -She would update Resident #1's record as soon as she possibly could. There were no current quarterly profiles provided for Resident #1 prior to survey exit. 3. Review of Resident #9's current FL-2 dated 3/29/17 revealed diagnoses included Alzheimer's	D 464		

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D 464	Continued From page 126 Dementia, Essential Hypertension, Cataracts, Gastro-esophageal Reflux Disease and Arthritis. Review of Special Care Unit (SCU) quarterly profiles for Resident #9 revealed the most recent profile was completed 10/7/16. 4. Review of Resident #2's current FL-2 dated 3/29/17 revealed: -Diagnoses included Alzheimer's dementia and hypertension. -Resident #2 was intermittently disoriented. Review of Resident #2's Resident Register revealed the resident was admitted to the Special Care Unit (SCU) on 8/17/15. Review of the Special Care Unit Quarterly Profile for resident revealed no quarterly profile had been completed for Resident #2. Interview with the Memory Care Manager (MCM) on 12/21/17 at 5:15 p.m. revealed; -If a quarterly profile was not in Resident #2's record, a quarterly profile had not been completed for Resident #2. -She was responsible for doing the SCU quarterly profile for Resident #2. -She had not had the opportunity to do an updated quarterly profile for Resident #2. 5. Review of Resident #6's current FL-2 dated 3/29/17 revealed: -Diagnoses included vascular dementia without behavior disturbances, hypertension, hypothyroidism, generalized anxiety disorder and abnormal weight loss. -Resident #6 was documented as constantly	D 464		

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D 464	Continued From page 127 disoriented. Review of Resident #6's Resident Register revealed the resident was admitted to the Special Care Unit (SCU) on 10/31/16. Review of Resident #6's current Care Plan dated 3/3/17 revealed: -The resident was always disoriented. -The resident had significant memory loss, and she had to be redirected. -The resident wandered. Review of the SCU Quarterly Profile for Resident #6 revealed a quarterly profile was completed on 5/3/17 and 8/11/17. Interview with the Memory Care Manager (MCM) on 12/21/17 at 5:15 p.m. revealed she had completed an updated quarterly profile for Resident #6 on 12/21/17. Interview with the Memory Care Manager (MCM) on 12/21/17 at 5:00 p.m. revealed: -She was responsible for during the quarterly profile for the residents on the Special Care Unit (SCU). -The profiles should be done quarterly. -She would be responsible for auditing the SCU profiles. 6. Review of Resident #12's current FL-2 dated 10/26/17 revealed diagnoses included Alzheimer's Vascular Dementia, dysphagia, cerebral vascular incident and hypothyroidism.	D 464		

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D 464	Continued From page 128 Review of Resident #12's Resident Register revealed the resident was admitted to the facility on 1/29/15. Review of the Special Care Unit Quarterly Profile for Resident #12 revealed: -The last quarterly profile was completed on 10/27/16. -There was not current quarterly profiles in the resident record. Refer to interview with the Memory Care Manager on 12/21/17 at 5:00 p.m. 7. Review of Resident #13's current FL-2 dated 3/29/17 revealed diagnoses of dementia, hyperlipidemia, obesity and high blood pressure. Review of Resident #13's Resident Register revealed the resident was admitted to the facility on 3/1/17. Review of the Special Care Unit Quarterly Profile for Resident #13 record revealed there was no documentation of a quarterly profile in the residents record. A second review of Resident #13's Special Care Unit Quarterly Profiles revealed: -The facility submitted a quarterly profile dated 12/21/17. -There were no changes in the resident's care. -The profile revealed the resident's prior quarterly profile was completed on 8/30/17. Refer to interview with the Memory Care Manager on 12/21/17 at 5:00 p.m.	D 464		

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D 465	Continued From page 129	D 465		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure adequate staffing to meet the needs of the resident on the Special Care Unit (SCU) on 34 of 45 shifts sampled from 5/19/17-5/20/17; 5/31/17-6/1/17; 7/1/17-7/2/17; 10/21/17-10/22/17; 10/28/17-10/29/17; 11/10/17-11/11/17; and 12/9/17-12/10/17, resulting in an undocumented fall with a lip injury and incidents of resident to resident assault for two residents (#3 and #16). The findings are: Interview with a guardian/family member on 12/18/17 at 1:30 p.m. revealed: -There were hardly any staff on the floor during second shifts and on the weekends. -There were not enough staff working on the floor. -The few staff that were working at the facility were too busy in the bathrooms or in the dining rooms assisting residents and were not available	D 465	ED, CM, and/or BOM will review staffing daily for all shifts to ensure shifts are staffed according to regulation. ED will continue to hire and train qualified staff for all three shifts. ED and CM will monitor staffing needs and call outs. Any identified scheduling concerns will be addressed by ED. The ED, CM, Supervisor-In-Charge (SIC) will call staff not on schedule to ensure adequate staffing. Plan of correction date is 1/20/18.	

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D 465	Continued From page 130 on the halls. -The family had to walk around to locate a staff person. Telephone interview with a second family member on 12/18/17 at 2:09 p.m. revealed: -She was concerned the SCU did not have enough help. -She thought the weekends were always short-staffed. -There were "so many patients and not enough caregivers." -She thought the residents needed more supervision. Interview with a third family member on 12/19/17 at 11:05 a.m. revealed: -When the family member came to visit a resident, there were usually 3 PCAs and 1 MA working in the SCU. -On weekend, there were usually 2 PCAs and 1 MA in the SCU. Interview with a MA on 12/19/17 at 5:22 p.m. revealed: -In the past there were 2 MAs and 4 PCAson each shift. -She did not recall how long it had been since they had 2 MAs and 4 PCAs on each shift in the Special Care Unit (SCU). Confidential interview with a staff revealed: -The staff worked all three shifts. -Since June 2017, the usually staffing pattern during first and second shifts were 4 PCAs, and 1 MA on the SCU. -During third shift, 3 PCAs worked in the SCU and there was 1 MA who worked on the AL and SCU. -The above had been the usually staffing pattern	D 465		

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D 465	Continued From page 131 since June 2017. Confidential interview with a second staff revealed: -The staff member worked first and second shift. -There were usually 4 PCAs and 1 MA during first and second shifts. -The staff did not know about the staffing pattern during third shift. -With 4 PCAs and 1 MA, there was still not enough staff, because certain residents required more one on one care. Confidential interview with a fourth staff revealed: -Most days there were three PCAs and one MA on 2nd shift which was not enough for 35-40 residents and specifically for the supervision needs of aggressive residents. -Staff was usually spread thin and there were not enough to do the job. -The facility also employed a red dot system which placed a mark beside the name of a staff each designated to stay if the oncoming shift was short staffed. -Usually this led to staff not doing the job they were supposed to do because they did not want to be there and were tired. Confidential interview with a fifth staff revealed: -There were not enough staff to cover both units. -Staff had to work over several times during the month to cover both the AL and SCU unit. Confidential interview with a sixth staff revealed: -Most of the time, staff were attending to the residents the best they could and were not able to be on the halls. -Residents were unsupervised by staff most of the time because staff were busy in the bathrooms or dining rooms of the SCU.	D 465		

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D 465	Continued From page 132 -The SCU was a locked unit and it was okay for residents to roam the halls. Review of staff punch details, staff schedule and daily census report for 5/19/17 revealed: -There were 38 residents in the SCU which required 38 aide hours for 1st and 2nd shift, and 30.4 aide hours for 3rd shift. -There were 30.14 aide hours for 2nd shift, leaving the SCU short 7.86 aide hours. -There were 21.58 aide hours for 3rd shift, leaving the SCU short 8.82 aide hours. -There were 87 residents in the facility (49 on the Assisted Living side), which required 58 aide hours for 1st and 2nd shift and 46.4 aide hours for 3rd shift. -There were 48.92 aide hours for the building for 2nd shift, leaving the building short by 9.08 aide hours. -There were 32.85 aide hours for the building for 3rd shift, leaving the building short by 13.55 aide hours. Based on observations, interviews and record reviews, a resident in the SCU was observed on 5/20/17 at 7:35am, by the staff and the resident's Power of Attorney, to have a swollen lip, "busted from the inside out." Staff did not know how this injury occured. Review of staff Punch Details and the facility census report for 5/20/17 revealed: -There were 39 residents in the SCU which required 39 aide hours for 1st and 2nd shift, and 31.2 aide hours for 3rd shift. -There were 29.48 aide hours for 1st shift leaving the SCU short 9.52 aide hours. -There were 32.17 aide hours for 2nd shift leaving the SCU short 6.83 aide hours. -The there were 21.87 aide hours for 3rd shift	D 465		

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D 465	Continued From page 133 leaving the SCU short 9.33 aide hours. -There were 88 residents in the facility (49 on the Assisted Living side), which required 59 aide hours for 1st and 2nd shift and 47.2 aide hours for 3rd shift. -There were 48.18 aide hours for the building for 1st shift, leaving the building short by 10.82 aide hours. -There were 49.30 aide hours for the building for 2nd shift, leaving the building short by 9.7 aide hours. -There were 32.94 aide hours for the building for 3rd shift, leaving the building short by 14.26 aide hours. Review of staff Punch Details and the facility census report for 5/31/17 revealed: -There were 37 residents in the SCU which required 37 aide hours for 1st shift. -The staff time cards documented 35.7 aide hours for 1st shift, leaving the SCU short 1.27 aide hours. -There were 85 residents in the facility (48 on the Assisted Living side), which required 57 aide hours for 1st shift. -There were 46.93 aide hours for the building for 1st shift, leaving the building short by 10.07 aide hours. Review of staff punch details, staff schedule and daily census report for 06/01/17 revealed: -There were 39 residents in the SCU which required 41 aide hours for 1st and 2nd shift and 31.2 hours for 3rdshift. -On 06/01/17, there were 35.05 aide hours for 1st shift, 35.37 aide hours for 2nd shift and 21.49 hours for 3rd shift leaving the facility short staffed by 5.95 aide hours on 1st shift, 5.63 aide hours on 2nd shift and 9.71 hours for 3rd shift. -There were 46 residents on the AL side and 39	D 465		

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D 465	Continued From page 134 residents in the SCU which required 59 aide hours for the building for 1st and 2nd shift based and 47.2 aide hours for the building for 3rd shift. -There were 63.07 aide hours for the building for 1st shift. -There were 51.17 aide hours for the building for 2nd shift, leaving the building short 7.83 hours. -There were 29.65 aide hours for the building for 3rd shift, leaving the building short 17.55 hours. Review of staff punch details, staff schedule and daily census report for 07/01/17 revealed: -There were 41 residents in the SCU which required 41 aide hours for 1st and 2nd shift and 31.2 hours for 3rd shift. -On 07/01/17, there were 28.0 aide hours for 1st shift, 28.89 aide hours for 2nd shift and 14.18 hours for 3rd shift leaving the facility short staffed by 20.41 aide hours on 1st shift, 12.11 aide hours on 2nd shift and 17.02 hours for 3rd shift. -There were 42 residents on the AL side and 41 residents in the SCU which required 61 aide hours for the building for 1st and 2nd shift and 48.8 aide hours for the building for 3rd shift. -There were 58 aide hours for the building for 1st shift, leaving the building short staffed 3 aide hours.. -There were 56.95 aide hours for the building for 2nd shift, leaving the building short 4.05 aide hours. -There were 36.02 aide hours for the building for 3rd shift, leaving the building short 12.78 aide hours. Review of staff punch details, staff schedule and daily census report for 07/02/17 revealed: -There were 38 residents in the SCU which required 38 aide hours for 1st and 2nd shift and 30.4 aide hours for 3rd shift. -On 07/02/17, there were 29.44 aide hours for 1st	D 465		

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D 465	Continued From page 135 shift, 24.42 aide hours for 2nd shift and 21.91 aide hours for 3rd shift leaving the SCU short staffed by 8.56 aide hours on 1st shift, 13.58 aide hours on 2nd shift and 8.49 aide hours for 3rd shift. -There were 46 residents on the AL side and 38 residents in the SCU which required 58 aide hours for the building for 1st and 2nd shift and 46.4 aide hours for the building for 3rd shift. -There were 54.17 aide hours for the building for 1st shift, leaving the building short 3.83 hours. -There were 52.58 aide hours for the building for 2nd shift, leaving the building short 5.42 hours. -There were 47.84 aide hours for the building for 3rd shift. Review of staff punch details, staff schedule and daily census report for 10/21/17 revealed: -There were 38 residents in the SCU which required 38 aide hours for 1st and 2nd shift and 36.4 hours for 3rd shift. -On 10/21/17, there were 43.23 aide hours for 1st shift, 23.15 aide hours for 2nd shift and 7.48 hours for 3rd shift leaving the facility short staffed by 14.85 aide hours on 2nd shift and 28.92 aide hours for 3rd shift. -There were 45 residents on the AL side and 38 residents in the SCU which required 58 aide hours for the building for 1st and 2nd shift and 46.4 aide hours for the building for 3rd shift. -There were 59.29 aide hours for the building for 1st shift. -There were 52.31 aide hours for the building for 2nd shift, leaving the building short 5.69 hours. -There were 18.77 aide hours for the building for 3rd shift, leaving the building short 27.63 hours. Review of the staff punch details, staff schedule and daily census report for 10/22/17 revealed: -There were 38 residents in the SCU which	D 465		

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required 38 aide hours for 1st and 2nd shift and 36.4 hours for 3rd shift.
-On 10/22/17, there were 40.00 aide hours for 1st shift, 40.4 aide hours for 2nd shift and 18.75 aide hours for 3rd shift leaving the facility short staff by 17.65 on 3rd shift.
-There were 44 residents on the AL side and 38 residents on the SCU which required 58 aide hours for the building for 1st and 2nd shift and 46.40 aide hours for the building for 3rd shift.
-There were 54.68 aide hours for the building for 1st shift, leaving the building short by 3.32 aide hours.
-There were 63.3 aide hours for the building for 2nd shift
-There were 30.43 aide hours for the building for the 3rd shift, leaving the building short by 15.97

Review of the staff punch details, staff schedule and daily census report for 10/28/17 revealed:
-There were 37 residents in the SCU which required 37 aide hours for 1st and 2nd shift and 34 hours for 3rd shift.
-On 10/28/17, there were 35.00 aide hours for 1st shift, 34.25 aide hours for 2nd shift and 32.75 aide hours for 3rd shift leaving the facility short staff by 2.00 aide hours on 1st shift, 2.75 aide hours on 2nd shift and 1.25 aide hours on 3rd shift.
-There were 43 residents on the AL side and 37 residents on the SCU which required 57 aide hours for the building for 1st and 2nd shift and 45.6 aide hours for the building for 3rd shift.
-There were 50.00 aide hours for the building for 1st shift, leaving the building short by 7.00 aide hours.
-There were 54.75 aide hours for the building for 2nd shift, leaving the building short by 2.75 aide hours.
-There were 40.00 aide hours for the building for

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D 465	Continued From page 137 3rd shift, leaving the building short by 5.6 aide hours. Review of an incident/accident report for a resident who resided on the SCU on 10/28/17 revealed an unwitnessed sexual encounter occurred between two residents on the SCU on 1st shift in the dining room. Review of the staff punch details, staff schedule, and daily census report dated 10/29/17 revealed: -There were 38 residents in the SCU which required 38 aide hours for 1st and 2nd shifts. -There were 28.57 aide hours for 1st shift which left the SCU short 9.43 aide hours. -There were 14.9 aide hours for 2nd shift which left the SCU short 23.1 aide hours. Review of the staff punch details, staff schedule, and daily census report dated 11/10/17 revealed: -There were 38 residents in the SCU which required 38 aide hours for 1st and 2nd shifts, and 30.4 aide hours for 3rd shift. -There were 37.24 aide hours for 1st shift which left the SCU short 1.16 aide hours. -There were 26.31 aide hours for 2nd shift which left the SCU short 11.69 aide hours. -There were 14.49 aide hours for 3rd shift which left the SCU short 15.91 aide hours. Review of Accident/Incident Reports dated 11/11/17 at 6:30am and 6:55am revealed two residents were hit in the face by a resident with known aggressive behvaiors. Review of the staff punch details, staff schedule, and daily census report dated 11/11/17 revealed: -There were 38 residents in the SCU which required 38 aide hours for 1st and 2nd shifts, and 30.4 aide hours for 3rd shift.	D 465		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 138 -There were 26.8 aide hours for 1st shift which left the SCU short 11.2 aide hours. -There were 31.42 aide hours for 2nd shift which left the SCU short 6.58 aide hours. -There were 18.25 aide hours for 3rd shift which left the SCU short 12.15 aide hours. Review of staff punch details, staff schedule and daily census report for 12/9/17 revealed: -There were 39 residents in the SCU which required 39 aide hours for 1st and 2nd shift and 37.6 hours for 3rd shift. -On 12/9/17, there were 34.48 aide hours for 1st shift, 44.84 aide hours for 2nd shift and 22.04 aide hours for 3rd shift leaving the facility short staffed by 4.52 aide hours on 1st shift and 14.94 aide hours for 3rd shift. -There were 48 residents in the AL side and 39 residents in the SCU which required 59 aide hours for the building for 1st and 2nd shift and 47.20 aide hours for the building for 3rd shift. -There were 58.15 hours for the building for 1st shift, leaving the building short .85 hours. -There were 71.82 hours for the building for 2nd shift. -There were 39.84 hours for the building for 3rd shift, leaving the building short 7.36 hours. Review of staff punch details, staff schedule and daily census report for 12/10/17 revealed: -There were 39 residents in the SCU which required 39 aide hours for 1st and 2nd shift and 37.6 hours for 3rd shift. -On 12/10/17, there were 29.08 aide hours for 1st shift, 29.24 aide hours for 2nd shift and 14.94 aide hours for 3rd shift leaving the facility short staffed by 10.08 aide hours on 1st shift, 8.76 aide hours on second shift and 22.66 aide hours for 3rd shift. -There were 48 residents in the AL side and 39	D 465		

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D 465	Continued From page 139 residents in the SCU which required 59 aide hours for the building for 1st and 2nd shift and 47.20 aide hours for the building for 3rd shift. -There were 60.79 hours for the building for 1st shift. -There were 62.40 hours for the building for 2nd shift. -There were 26.90 hours for the building for 3rd shift, leaving the building short 20.30 hours. Interview with the Memory Care Manager (MCM) on 12/19/17 at 11:00 a.m. revealed: -She had been covering as the MCM and as the Resident Care Manager (RCM) since she started working at the facility in June 2017. -She was responsible for overseeing bot the SCU and the AL. -She was responsible for assisting staff with any needs or concerns they had in providing care for the residents. -She tried to spend the majority of her day on the SCU, but the printer for all documents was on the AL side and all meetings were on the AL side. -She estimated that two to three hours of her day were spent on the AL side. Interview with the MCM on 12/20/17 at 2:49 p.m. and 12/21/17 at 2:13 p.m. revealed: -There staffing issues related to call outs and high turnover in staff at the facility. -She had stayed and worked 2nd shift and she had come in to cover 3rd shift because there was no else to work. -She had not kept track of hours and shifts she had worked covering as direct care staff. -Sometimes she may have come in at 4:00 a.m. or 5:00 a.m. because of an emergency or a call out. -She could not remember the last time she had to stay for 2nd shift or come in for 3rd shift.	D 465		

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D 465	Continued From page 140 -She worked once for a full 2nd shift and came in twice on 3rd shift since she started working at the facility in June 2017. Interview with the MCM on 12/21/17 at 2:13 p.m. revealed: -When there was one MA on duty for 3rd shift, the MA's time was split between the AL side and the SCU. -For example, if the MA worked 8 hours on 3rd shift, four hours were on the AL side and four hours were on the SCU. Interview with the Administrator on 12/21/17 at 2:13 p.m. revealed: -He was aware the facility had staffing issues. -The facility had a red dot system in place to cover short shifts. -The red dot system identified a staff each shift who was designated to stay and work if the oncoming shift was short staffed. -All staff who worked a given shift were accounted for on the punch details report. -He did not have a response for the quality of care staff were able to provide when staff had to stay for mandatory shifts in a SCU and possibly for several mandatory shifts each week. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care & Supervision (Type A1 Violation)] [Refer to Tag 338 10A NCAC 13F .0909 Residents' Rights (Type A1 Violation)] The facility's failure to assure adequate staffing for 34 shifts resulted in serious harm and neglect for a resident who sustained a lip injury on 5/19/17 when the SCU was short 7.86 aide hours on the 2nd shift and 8.82 aide hours on 3rd shift; and two additional residents who were hit in the	D 465		

Division of Health Service Regulation

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D 465	Continued From page 141 face by a resident known to have aggressive behaviors on 11/10/17 for third shift when the facility was short 15.91 aide hours which constitutes a Type A2 Violation. Review of the Plan of Protection submitted by the facility on 7/14/17 revealed: -The facility will immediately review staffing for all shifts to ensure that shifts are staffed according to state guidelines. -This will be assured by scheduling and monitoring of staff that calls in or does not come in to work. -This will monitored every shift by the Memory Care Manager (MCM), Resident Care Manager (RCM), and the Administrator. -The facility will continue to hire and train qualified staff for all three shifts. -Staffing levels will be monitored and checked every shift for appropriateness by the Administrator and Care Managers. -If staff fails to arrive for their shifts employees currently at work must remain in the building until relief arrives. -Any staff leaving the community before [the next] shift will be counseled and retrained on policy. -Administrator and Care Managers will sign off on all violation documentation. -If the building is short staffed, the Care Managers, Supervisors and Administrator will call on those not currently on the schedule to cover openings. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 20, 2018.	D 465	Note: Plan of Protection submitted on 12/20/17 not 7/14/17 as noted.	
D914	G.S. 131D-21(4) Declaration of Residents' Rights	D914	All staff shall be oriented and trained on the importance of understanding	

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D914	Continued From page 142 G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to provide the services necessary to maintain the residents' physical and mental health related to Supervision, Residents' Rights, Special Care Unit Staffing and Health Care. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to provide the supervision necessary to prevent 3 of 11 sampled residents (#1, #2, #9), with known physical aggression and sexually expressive behaviors, from hitting, pushing and pursuing other residents on the Special Care Unit (SCU) resulting in one resident sustaining a broken pelvis (#10) and another resident (#1), who was incapable of consenting due to cognitive status, being lured into an unwitnessed sexual encounter. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care & Supervision (Type A1 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to assure 8 residents (#1, #6, #10, #14, #15, #16, #17 and #18) who resided on the Special Care Unit (SCU) were protected from assualt by Resident #9 who was known to have aggressive behaviors; and residents on the SCU were protected from assualt by Resident #1 who was also known to have aggressive behaviors. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)].	D914	residents rights upon hire. Per community compliance all new staff is required to complete Fels training related to resident rights and signing statement of acknowledgement of resident rights form. Current staff has received in-service training from Ombudsmen on 1/10/18 and 1/25/18. All current staff is required to complete resident rights training annually. ED, CM, and BOM will ensure all staff adheres to Declaration of residents rights. Plan of correction date is 2/4/18.	

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D914	Continued From page 143 3. Based on observations, interviews and record reviews, the facility failed to assure adequate staffing to meet the needs of the resident on the Special Care Unit (SCU) on 34 of 45 shifts sampled from 5/19/17-5/20/17; 5/31/17-6/1/17; 7/1/17-7/2/17; 10/21/17-10/22/17; 10/28/17-10/29/17; 11/10/17-11/11/17; and 12/9/17-12/10/17, resulting in an undocumented fall with a lip injury and incidents of resident to resident assault for two residents (#3 and #16). [Refer to Tag 465, 10A NCAC 13F .1308(a) Special Care Unit Staff (Type A2 Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider for 2 of 2 sampled residents (#1, #8) related to the sexual assault of Resident #1 and the sexually expressive behaviors of Resident #8. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D914		